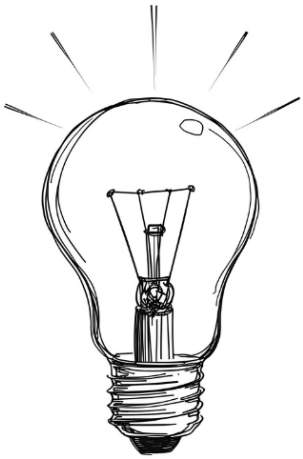
Deliverable 5.3:
Recommendations for Improvement of TtT and Curricula Implementation



Victim Protection in Medicine

Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence

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No.	Acronym	Institution	Country
1	WWU	Universität Münster	Germany
2	VICESSE	Vienna Centre for Societal Security	Austria
3	IKF	Institut für Konfliktforschung	Austria
4	GES	GESINE Intervention (Frauen helfen Frauen EN e.V.)	Germany
5	UU	Uppsala Universitet	Sweden
6	HFPA	Elliniki Psychiatrodikastiki Etaireia	Greece
7	AOU-PR	Azienda Ospedaliero-Universitaria di Parma	Italy
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Abbreviations and acronyms

Df	Difference between surveys Q1, Q2, Q3
DV	Domestic Violence
Fig.	Figure
M	Mean value
N	Number of participants in the survey (for a given question)
Q1	Questionnaire 1 (1st round of survey)
Q2	Questionnaire 2 (2nd round of survey)
Q3	Questionnaire 3 (3rd round of survey)
Tab.	Table

Table of Contents

1. Executive Summary

The VIPROM-project ("Victim protection in medicine: Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence") has ambitious goals of developing and implementing training modules (medical curricula) specifically tailored to the needs of medical and healthcare professionals in five countries to provide appropriate and responsive support to victims of domestic violence (DV). This deliverable covers the results of the evaluation of pilot trainings held for medical professionals as well as medical students in all partner countries.

The goal of the evaluation was to measure training success – i.e. participants' feedback and their sustainable growth of competencies, in terms of knowledge as well as skills. In order to do so a multi-method approach was developed (see Deliverable 5.1 for the evaluation strategy) that included participants' and trainers' perspectives and made use of observation as a third methodical approach. As the VIPROM-project offered the possibility to survey training participants at three points in time, evaluations were done directly before and after the training and six months after completion, thereby allowing evaluators to assess not only immediate trainings effects, but also their sustainability.

This report presents the findings from the evaluation, which shows the VIPROM-trainings to be highly effective for all stakeholder-groups over all dimensions (participant satisfaction, learning effects in terms of knowledge and skills, sustainability). The evaluation pins down possible reasons for this success, i.e. evaluators try to show evidence for the impact of the specific didactic approach developed in the programme. It concludes with a summary of findings and recommendations for the further development of the VIPROM-curricula.

2. Introduction

This report focusses on the results of the evaluation of the stakeholder DV violence trainings and builds on previous work. For a comprehensive overview of the trainings themselves see Deliverable 4.2 Report on the Piloting of the Training Curricula, for an explication of the rationale for the multi-method evaluation design see D 5.1).

In order to allow for a comprehensive presentation of the evaluation's results the report is structured according to the different perspectives represented in the evaluation material. First, we present our analysis of participants' training experiences as collected through a three-wave survey (pre- and post-training, six months after completion). In addition to participants' feedback on the trainings in terms of content and didactics, the surveys also captured their self-evaluation in terms of knowledge about DV and competencies in dealing with DV-victims as well as a short knowledge assessment. Second, we analyse the training observations, which were collected by all partners during the pilot trainings in the different national settings. These reports offer qualitative data in the form of "thick descriptions" of the trainings. Third, we present trainers' perspectives on the VIPROM-project, which were collected at three different points in time. We start with results of trainers' feedback collected after the Train the Trainer-events. Then we turn to the short informal interviews with trainers in the course of the observations mentioned above, i.e. directly after delivering their own trainings. Last, international focus groups with trainers, which were conducted in spring 2025, provided a space for reflection and further nuance. All surveys, forms and documents used to collect evaluation data are documented in the annex of this report.

After presenting the findings of the different methods in separate sections, the results are integrated in the conclusions of this report.

3. Participant Surveys

In order to assess the (lasting) impact of the VIPROM-trainings, trainees were given questionnaires at three points in time: At the beginning (Q1) and end of the in-person trainings (Q2) and six months afterwards (Q3). The first two questionnaires (Q1, Q2) were presented to the medical students and professionals as paper-pencil questionnaires by the VIPROM-trainers; the data was then processed by the partners and sent to the IKF in anonymized form (Excel, see the Code Book Annex 7.7). The third questionnaire was programmed multilingually by IKF using SoSci and sent to the trainees six months after the training sessions by the project partners or their trainers.

The questionnaires, which were submitted before the trainings (Q1), consist of three blocks of questions (see Annex 7.1, Annex 7.4):

(1) General questions, which, in addition to socio-demographic data such as gender (male, female, diverse/non-binary/queer, other) and age, ask about previous work experience in hospitals, the extent to which cases of domestic violence have been perceived in hospitals to date and, in the case of medical professionals, their occupational group.

(2) Self-assessment questions relating to general and specific medical knowledge about domestic violence (e.g. most common forms of domestic violence, relevant guidelines, risk assessment tools) as well as skills in perceiving and dealing with domestic violence (e.g. knowing indicators of domestic violence, being competent to communicate with victims).

(3) Multiple-choice questions to assess knowledge about domestic violence in a more objectified fashion. In order to give respondents the opportunity to share further thoughts, experiences or wishes, there were open fields at the end of each block of questions.

The conceptualisation and operationalisation of items that measured increases in knowledge and skills about domestic violence presented a challenge: Self-assessment questions by definition measure subjective impressions, which are prone to be influenced by a broad range of factors (e.g. gender, age, national and institutional context). With regard measuring knowledge(-gains) this problem was solved by including multiple-choice questions in the questionnaires – these enable an assessment of the extent to which the training has led to an objectively verifiable training effect, but pose their own difficulties and short-comings. A comparable strategy was not possible for practice-oriented competencies.

In addition to the question blocks already described, the questionnaire submitted at the end of the training sessions (Q2) also collected feedback on the training sessions and their perceived effects (see Annex 7.2, Annex 7.5). The third questionnaire (Q3), which was sent to medical students and medical professionals six months after the training, included (1) general questions and (2) questions about the training, focusing on applicability and sustainability (e.g. applicability of training content to area of work, changes in communication with victims of domestic violence or DV-related practices; see Annex 7.3, Annex 7.6). Q3 again included a self-assessment regarding knowledge and skills on domestic violence as well as multiple-choice questions.

Various measures were taken to reduce the likelihood of early termination of the last online-questionnaire (Q3), for example, it was possible to save the questionnaire temporarily and thus continue it after an interruption. Furthermore, the number of mandatory questions was deliberately kept to a minimum. Answers were only mandatory if this was necessary for a meaningful evaluation of the data.

The three survey dates make it possible to empirically demonstrate the impact of VIPROM-training and to make evidence-based statements about its sustainability. Using identical question blocks or individual items in all three surveys enabled comparisons of the results.

3.1. Sample Descriptions

The sample of medical students consists of 272 valid cases in the first survey (Q1) and 269 valid cases in the second survey (Q2), respectively. For the group of medical professionals, there are 198 valid cases for the first (Q1) and 197 for the second survey (Q2). For the third survey (Q3), conducted six months after the training sessions, there are 120 valid cases for medical students and 134 for medical professionals.

In any survey conducted over various points in time, a dropout rate among respondents can be expected, meaning that the sample sizes of the three surveys differ, which complicates direct comparability of results. However, it is common practice in research to consider a sample difference of less than 5% acceptable for direct comparison – as long as there are no anomalies in the data concerning the dropouts (e.g. if all these cases were from a specific training). For Q2, the dropout rate for both medical students and medical professionals is less than 5% and it is therefore permissible to compare data (e.g. mean values) despite the slightly different sample sizes. This is however not the case for Q3 – which came as no surprise given that this was an online questionnaire after a considerable amount of time. Therefore results for Q3 are not directly comparable to the first two surveys in a statistical sense, but they still

show trends, which can be meaningfully interpreted. These reservations of course do not impede the interpretation of Q3's results as such but only refer to comparability.

Since the number of valid cases for both medical students and medical professionals is almost identical across the first two questionnaires (Q1, Q2), the sample for these two groups is described exclusively on the basis of data from the first questionnaire survey (Q1). Since the number of valid cases noticeably decreased for Q3, the respective samples will be discussed separately. In general the number of valid answers (n=X) is given for each question as some respondents skipped single questions.

3.1.1. Medical Students

Of the 272 medical students who attended a VIPROM-training, the largest group came from Italy (132, 48,5%), followed by Germany (56, 20,6%), Greece (44, 16,2%), and Austria (40, 14,7%), respectively (Fig. 1). In terms of gender distribution, the majority of trainees were female: 213 medical students were women (78,6%) and 58 were men (21,4%), no participant picked diverse/non-binary/queer or other. In Germany, out of 56 trainees, 51 were female (91,1%), followed by Greece with 36 out of 44 being female (81,8%). In Italy out of 131 students 98 were women (74,8%) and in Austria 28 (70%) out of 40.

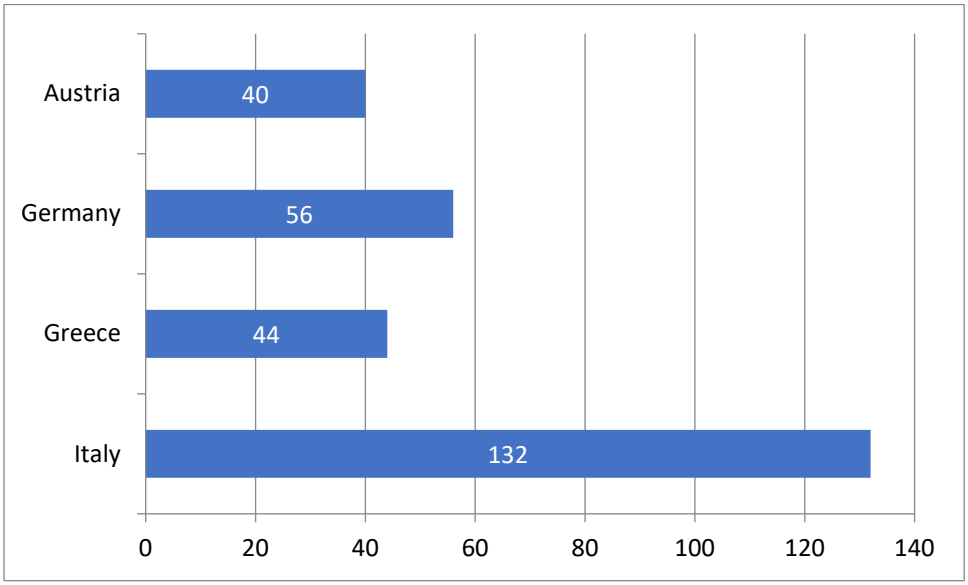


Figure 1. Countries medical students were coming from (Q1, n=272) ***[n=number of students in total for Q1]***

The largest age group was 20 to 24-year-olds (135, 49,6%), followed by 16 to 19-year-olds (84, 30,9%). Another 39 medical students (14,3%) were between 25 and 29 years old, and 14 (5,1%) were older than 30.

Asked about previous work experience in hospitals (n=265) 122 students (46%) had already worked in a hospital, while 143 (54%) had not. A comparison between countries shows that in Austria, all trained students had already worked in hospitals (40, 100%), in Germany 44 out of 50 (88%) and in Greece 30 out of 44 (68,2%) – only in Italy did the majority of students (123 out of 131, 93,9%) have no previous work experience in hospitals (Fig. 2).

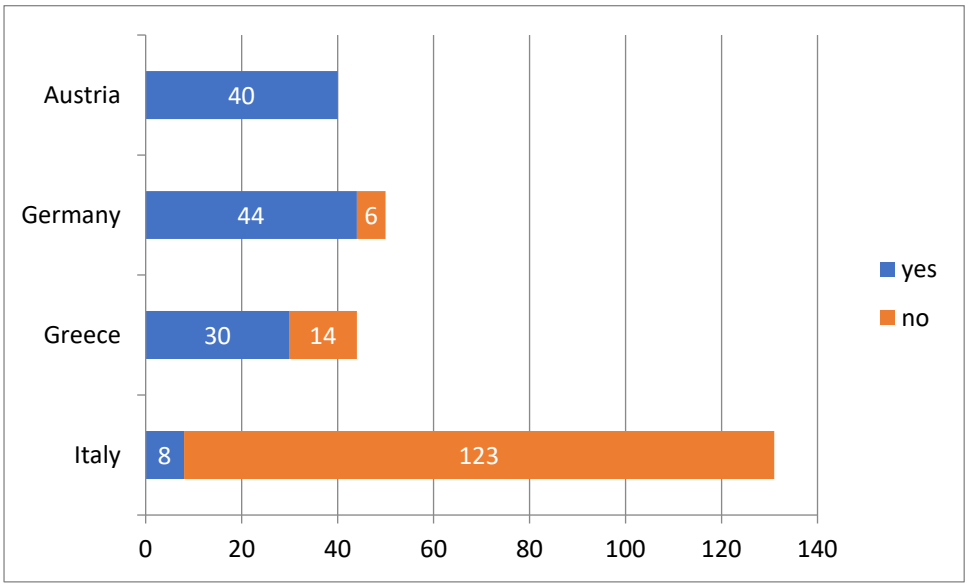


Figure 2. Work experience in hospitals stratified by country (medical students; Q1, n=265) ***[n=number of students answering this question in Q1]***

Of the 122 medical students with prior experience, 37 (30.3%) had perceived cases of domestic violence in hospitals in the past 12 months, 81 (66,4%) had not, for one the question was not applicable and three did not answer the question.

When looking at the country distribution of medical students, who responded to the questionnaires six months after their training (Q3), the following shows: most respondents are from Italy (60, 50%), followed by Greek students (35, 29,2%). 18 students from Germany answered the survey (15%) and lastly 7 (5,8%) answers came from Austria.

As with the original student sample, that took part in the VIPROM-trainings, the majority of students were female (97, 80,8%) and 23 students (19,2%) were male.

The age distribution is similar as well, with the largest age group being 20 to 24-year-olds (84,70%), followed by 17 16 to19-year-olds (14,2%), eight (6,7%) 25 to 29-year-olds and eleven students (9,2%) older than thirty years.

The same trend is visible when looking at reported work experience in hospitals. Out of 120 students, 56 (46,7%) have worked in hospitals six months after the training, while 64 (53,3%) have not. Taking a differentiated look at work experience stratified by country of the participants, the pre-training distribution persists, with Austria, Germany and Greece students already mostly having worked in hospitals, while Italian students have not (Fig. 3).

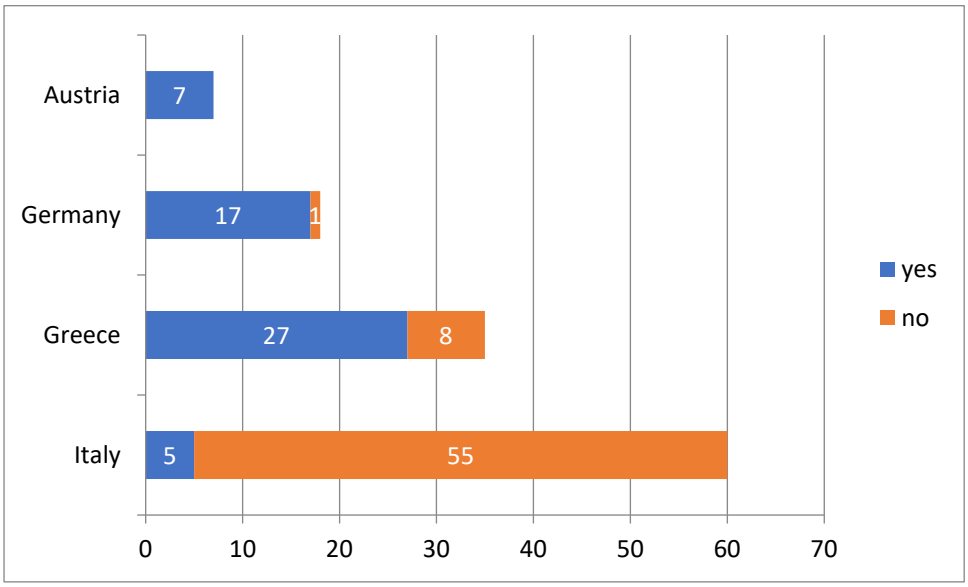


Figure 3. Work experience in hospitals stratified by country (medical students; Q3, n=120). ***[n=number of students answering this question in Q3]***

Lastly, of the 56 students with experience in hospitals 21 (37,5%) had perceived cases of domestic violence in hospitals in the last 12 months.

3.1.2. Medical Professionals

Of the 198 medical professionals answering Q1, 102 (51,5%) attended a VIPROM-training in Italy, followed by 44 medical professionals in Sweden (22,2%), 39 in Greece (19,7%), and 13 in Austria (6,6%) (Fig. 4). As with medical students, the majority of medical professionals were female (174, 87,9%), with only 24 men (12,1%) attending a VIPROM-training. The gender distribution of trained medical professionals across all countries was similar to that of the medical students, with women making up between 77% and 91% of trainees.

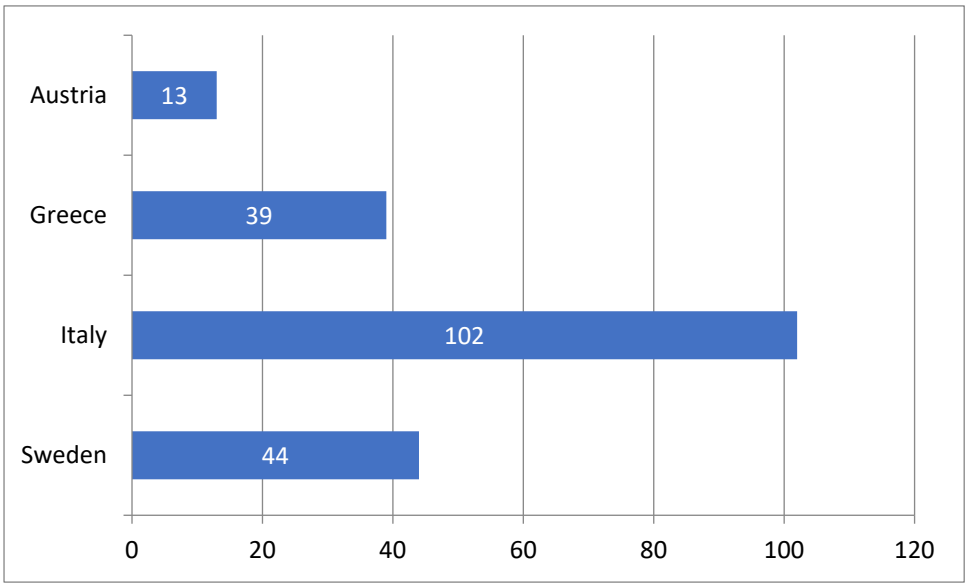


Figure 4. Countries medical professionals were coming from (Q1, n=198) ***[n=number of medical professionals in total for Q1]***

The age group of 50 to 59-year-olds is most strongly represented (62, 31,6%), followed by the age group of 40 to 49-year-olds (47, 24%) and 30 to 39-year-olds (39, 19,9%). Twenty-three medical professionals (11,7%) were between 60 and 69 years old, and another four (2%) were between 70 and 79 years old. Twenty-one people (10,7%) from the youngest age group (20-29) attended a training.

The most common professions among medical professionals were doctors (86, 43,4%) and nurses (67, 33,8%). In addition, 20 psychologists (10,1%) and 16 midwives (8,1%) have completed a VIPROM-training. Nine people reported other professions, for example physiotherapists or counsellors. It is noteworthy that all professions consisted of between 84% and 90% women – with the exception of midwives and those choosing "other", where exclusively women attended the trainings (Fig. 5).

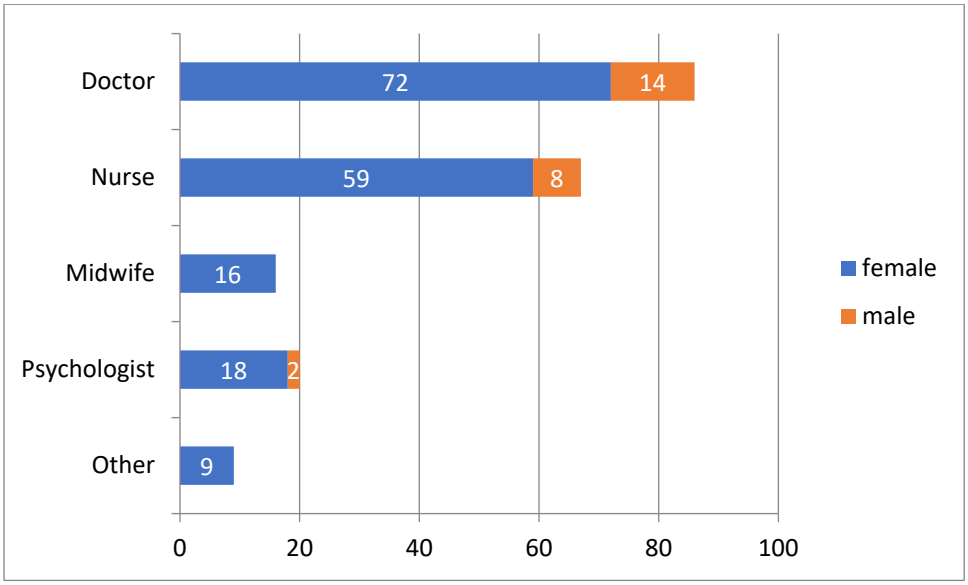


Figure 5. Professions by gender (medical professionals; Q1, n=198). ***[n=number of medical professionals answering Q1]***

In line with the age distribution described above, the vast majority of medical professionals taking part in VIPROM-trainings had a lot of experience working in hospitals. More than half of the participants (101; 51%) have been working in hospitals for over ten years, 26 (13,1%) for five to ten years. 30 medical professionals (15,2%) have been working in hospitals for between one and five years, and only five (2,5%) for less than a year. The question did not apply to 36 respondents (18,2%), meaning they were/are not employed in a hospital but had their own private practices or other professional circumstances.

Not surprisingly medical professionals reported far more experiences with DV than students. When asked about DV experiences in the last 12 months (n=193), 103 people (53,4%) answered yes, while 71 (36,8%) said they had not encountered any cases of domestic violence in the last year. The question did not apply to 19 people (9,8%) presumably due to their work environment. Looking specifically at doctors and nurses who were/are employed in hospitals a Chi-Square test of independence (p=0.05) was used to examine whether there was a significant correlation between belonging to one of these professional groups and the perception of cases of domestic violence (excluding those that had picked "not applicable"). However, while chi-square was significant, the correlation shown by Cramer's V was extremely weak. While standard residuals suggested – against expectations – that doctors

perceive DV more frequently than nurses, results are statistically weak and do not allow for a clear interpretation.

134 medical professionals answered Q3 six months after the VIPROM-training. This response rate was higher than that of medical students and data distribution in response to general questions on sociodemographic variables and work experience are highly similar to the pre-training sample. Looking at the country distribution, most medical professionals are from Italy (68, 50,7%), followed by Greece (39, 29,1%), Sweden (21, 15,7%) and Austria (6, 4,5%). Data from Greece is extraordinary in that 100% of respondents from Q1 and Q2 responded again after six months. This points to the high engagement and extraordinary commitment of Greek participants as well as trainers, but is also due to the fact that Greek participants had been presented the evaluation as an integral and obligatory part of the training. In all other locations response rates had dropped vis-à-vis Q1 reaching between 46% (Austria) and 67% (Italy).

Age-wise the largest group consists of 50 to 59-year-olds (48, 35,8%), followed by 40 to 49-year-olds (26, 19,4%), 25 30 to 39-year-olds (18,7%), 15 20 to 29-year-olds (11,2%) and one person above 70.

Concerning profession the largest groups again are doctors and nurses, followed by midwifes psychologists and other professions (e.g. physiotherapists). The majority of medical professionals are women (117, 87,3%), 17 medical professionals (12,7%) are men. Across all professions, the majority are women, with the exception of midwifes, who are all female (Fig. 6).

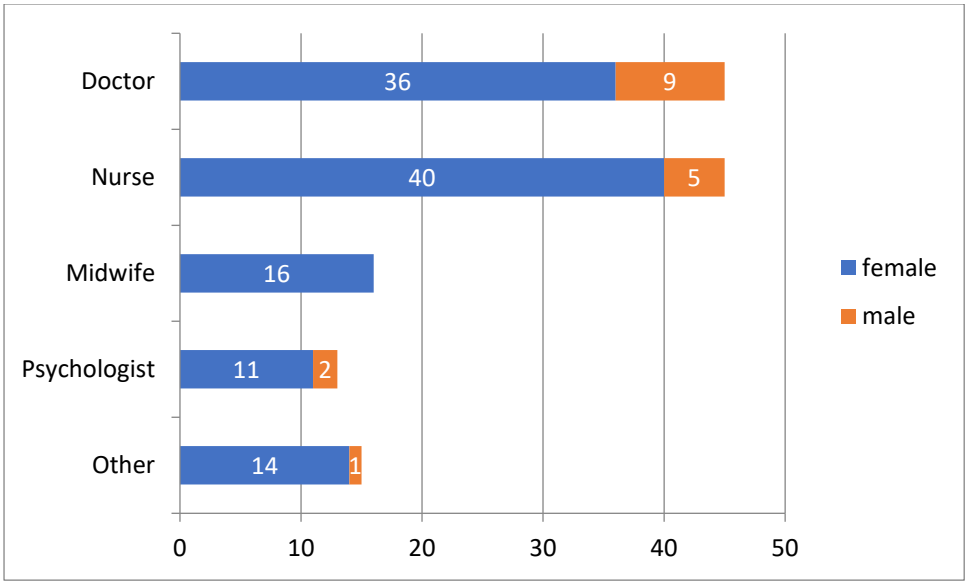


Figure 6. Professions by gender (medical professionals; Q3, n=134). ***[n=number of medical professionals answering Q3]***

The majority of medical professionals, who responded to the third questionnaire, worked in hospitals for more than 10 years (73, 54,5%), rates for medical professionals with a work experience of 1-5 years, 5-10 years or respondents who have not worked in a hospital are of similar sizes with 17 to 21 persons each and only 6 people reported less than one year of experience.

73 medical professionals (55,3%) had recognized cases of domestic violence in hospitals in the last 12 months, 50 (37,9%) had not – and for 9 respondents (6,8%) the question was not applicable. Again, this means that the distribution is very similar to Q1 and Q2.

In summary, the data shows that the VIPROM-trainings reached the intended target groups. In regard to the trained medical professionals, doctors and nurses were the largest sub groups. It is notable that the majority of medical professionals that participated have already worked in hospitals for several years. This highlights the need for domestic violence trainings like VIPROM not only for "newcomers", but also for experienced professionals.

3.2. Feedback Training

The questionnaires submitted after the training sessions (Q2) collected data on didactic aspects and methods of the training and the trainees' satisfaction with the training. When asked which methods trainers had used participants reported a great variety of approaches. Not surprisingly different versions of expert input (lectures, videos) played an important part in the trainings, but the wealth of interactive formats ranging from group work to various forms of experiential learning (scenarios, role play, simulations…) that was reported by students and professionals alike a trademark of the VIPROM-trainings (Tab. 1). This indicate trainers' adaptability to the needs of different participants as trainings for medical professionals relied more heavily on group work/discussions, i.e. the sharing of experiences and expertise among peers, than trainings for students, which involved simulations and scenario work more often.

Table 1. Didactic methods (number and percentage of respondents; Q2)

	Students		Professionals	
Methods	**Q2 (n=269)**	**Q2 %**	**Q2 (n=197)**	**Q2 %**
Input/lecture	254	94,4	194	98,5
Group work/group discussion	235	87,4	191	97,0
Videos	256	95,2	156	79,2
(Self-)Assessment	110	40,9	99	50,3
Case Studies	239	88,8	163	82,7
Simulations	122	45,4	65	33,0
Role Play	121	45,0	84	42,6
Other	4	1,5	0	0,0

3.2.1. Trainees' Satisfaction

With regard to trainee satisfaction, medical students and medical professionals alike expressed a high level of satisfaction across all aspects of training. The overall quality of the

trainings was rated by medical students (n=267) at an average of 8,63 on a scale of 1 to 10, and by medical professionals (n=197) at 9,15 (Tab. 2). Participants were also asked about a number of specific elements in connection with the structure and presentation of training contents and trainers' expertise and didactic competence which all received very high ratings. When asked about the relevance in the framework of university course work, medical students (n=268) granted an average score of 8,8. Even more importantly, the average score (9,28) was even higher among medical professionals (n=195), who were asked about the relevance of working with victims of domestic violence in hospitals. It speaks to the quality of the VIPROM-trainings that satisfaction remained high after six months (Q3). When comparing mean values across the two different questionnaires, they difference between mean is negligible.

Table 2. Rating of training aspects by trainees (1-10 scale; n=number of respondents, M=mean value; df M Q2-Q3=difference between mean values for Q2-Q3)

	Students					Professionals				
Item content	**Q2 n**	**Q2 M**	**Q3 n**	**Q3 M**	**df M Q2-Q3**	**Q2 n**	**Q2 M**	**Q3 n**	**Q3 M**	**df M Q2-Q3**
Overall quality of the training	267	8,63	120	8,60	-0,03	197	9,15	133	9,03	-0,12
Structure of the training	268	8,26	120	8,42	0,16	197	9,04	133	8,85	-0,19
Presentation of the content and teaching methods	267	8,74	120	8,56	-0,18	196	9,22	134	9,00	-0,22
Expertise of the trainers/teachers	268	9,24	119	9,01	-0,23	197	9,53	134	9,39	-0,14
Methodological and didactic competence of the trainers/teachers	267	9,00	120	8,83	-0,17	196	9,44	134	9,24	-0,20
Relevance in the framework of university course work	268	8,80	120	8,74	-0,06					
Relevance of working with victims of domestic violence in hospitals						195	9,28	133	9,03	-0,25

The data was further analysed to get a better understanding of the impact of the respective methods present in the VIPROM-trainings based on participants' feedback on the trainings. Spearman correlations were conducted to answer the question how the chosen number of methods that were used in the corresponding VIPROM-trainings impacted participants' ratings

of their quality. With medical students, data showed that the more different methods haven been used in trainings, the higher quality was rated – this held for the overall quality of the training (Spearman-ρ = .347, p < .001, n = 267) as well as the ratings for presentation and teaching methods (Spearman-ρ = .354, p < .001, n = 267). For medical professionals, Spearman correlations were also used to examine the extent to which the number of didactic methods used correlates with various aspects of participant's training ratings. A significant but weak positive correlation was found between the number of methods and the overall assessment of training quality (ρ = .176, p = .014) and the assessed expertise of the trainers (ρ = .167, p = .019). No significant correlations were found for the other aspects examined (structure of the training, presentation of the content and teaching methods, methodological and didactic competence of the trainers, and relevance for working with victims of domestic violence in hospitals).

For a more in-depth analysis, we examined the extent to which the number of didactic methods used affects training satisfaction for different professional groups (doctors vs. nurses). To this end, Spearman correlations were calculated between the number of different methods and various dimensions of training assessment. Among doctors (n=85), significant positive correlations were found between the number of methods used and the perceived overall quality of the training (ρ = .284, p = .008) as well as presentation and teaching methods (ρ = .234, p = .031). A slightly different pattern was observed in the group of nurses (n=70): Here, a significant positive correlation was found only with the perceived expertise of the trainers (ρ = .281, p = .019). In contrast, there were no significant correlations with the diversity of methods in terms of the quality, presentation, or structure of the training. The results suggest that doctors respond more strongly to a greater variety of methods in training, especially with regard to their quality and presentation of the content and teaching methods. For this professional group, training that is methodologically diverse seems to be rated more positively. With nurses, on the other hand the variety of methods correlates only with the assessment of the trainer's expertise, which may indicate that nurses perceive methodological scope as a sign of professional competence, but do not link it directly to their assessment of the training content.

Furthermore, it was analysed whether the number of interactive methods – i.e. group work, assessment, case studies, simulations, and role-playing – used in trainings impacted ratings of overall quality. For medical students, a linear regression analysis shows that the number of interactive methods has a significant influence on participants' satisfaction with the training ($F(1, 265) = 35.51$, $p < .001$). The model explains 11.8% of the variance in satisfaction ($R^2 = .118$). The unstandardised regression coefficient shows that with each additional interactive method, satisfaction increases by an average of 0,275 points (B = .275, p < .001). The effect is statistically significant. A multiple linear regression analysis was performed to investigate the extent to which the use of individual interactive teaching methods influences participants' satisfaction with the training. The overall rating of the quality of the training served as the dependent variable, while five dichotomous predictors (each: method used = 1, not used = 0) were included in the model. The regression model was significant overall, $F(5, 261) = 8.66$, $p < .001$, and explained 14.2% of the variance in perceived training quality ($R^2 = .142$). This corresponds to a small to medium effect according to Cohen (1988), who suggests R^2 values of .01 (small), .09 (medium), and .25 (large). A look at the individual predictors shows that the use of role-playing (β = .183, p = .011) and assessments (β = .166, p = .017) in particular were significantly positively correlated with perceived training quality. These methods had the strongest effects in the model and appear to be particularly relevant for participant satisfaction.

The other methods – case studies (β = .119, p = .067), simulations (β = .101, p = .135), and group work (β = –.083, p = .219) – showed no significant effects.

The same analysis was conducted for medical professionals. The regression coefficient is significant (B = 0.210, p = .001), i.e. with each additional interactive method, the assessment of training quality increases by an average of 0.21 points. The model explains approximately 5.3% of the variance with regards to assessments of training quality (R^2 = .053). The effect is statistically significant but rather small, suggesting that factors other than methodical diversity play a role in the assessment of quality. A separate regression analysis was also performed for doctors and nurses. A significant positive correlation was found for doctors: the standardized regression coefficient (beta) is 0.337 with a p-value of .002, indicating a moderate effect. The model explained 11.3% of the variance in perceived training quality (R^2 = .113). For nurses, however, the correlation was not significant. The beta coefficient was 0.165 with a p-value of .173. The model explained only 2.7% of the variance (R^2 = .027), indicating a very weak correlation.

To investigate the relationships between different interactive methods and the perceived overall quality of the training, a multiple regression analysis was performed for medical professionals. The overall model is significant ($F(5,191) = 7.788$, $p < .001$) and explains 16.9% of the variance in the dependent variable (R^2 = .169). Among the methods examined, only case studies show a significant positive effect (β = .388, p < .001). The other methods do not contribute significantly to predicting the overall quality of the training. For a more in-depth investigation, a multiple regression analysis was performed for physicians and nurses to gain better understanding on the impact of specific interactive training methods. For doctors, the regression model was significant ($F(5,79) = 4.10$, $p = .002$) and explained 20.6% of the variance in perceived quality (R^2 = .206). Among the predictors, the use of case studies was a particularly significant positive predictor (β = .330, p = .003), as was group work (β = .217, p = .037). The other methods did not show any significant influence. For nurses, the regression model did not reach statistical significance ($F(5,64) = 1.95$, $p = .098$) and explained only 13.2% of the variance (R^2 = .132). Despite this, case studies had a significant positive influence for nurses as well (β = .355, p = .004), while the other methods did not play a significant role. In both groups, the use of case studies was associated with a higher perceived overall quality of training. In addition, group work had a positive effect for doctors, but not for nurses. Overall, the model was statistically significant for doctors and explained more variance. This means that interactive methods appear to have a greater influence on the perceived quality of training among doctors than among nurses. This could indicate different expectations, prior experiences, or learning preferences between the professional groups and could be taken into account when designing future trainings.

3.2.2. Didactic Variety and Knowledge Gains

A further point of interest was the question, whether participants gained more knowledge on domestic violence, when more interactive methods were used. For medical students, a linear regression analysis indicates that the number of interactive methods is a significant predictor of reported knowledge gains after training (B = 0,152, p = .003). The model is significant overall ($F(1, 267) = 9.188$, $p = .003$) and explains 3.3% of the variance in knowledge gains attributed to the attended training (R^2 = .033). Although the effect is small, it is statistically significant: the more interactive methods were used in training, the higher medical students rated their knowledge on domestic violence gained by the training. A similar result has been found for

the overall score of the four multiple-choice questions (-24 to +24 points): Linear regression analysis shows that the number of interactive methods used in training is a significant predictor of performance on the multiple-choice questions on domestic violence (B = 0,628, p = .013). The model explains 2.3% of the variance in test results (R^2 = .023), indicating a weak but significant correlation. Each additional interactive method is associated with an average test score increase of 0,63 points.

A multiple linear regression analysis was performed to examine the extent to which the five different interactive teaching methods (group work, (self-)assessment, case studies, simulations, role play) explain medical student's self-assessed knowledge gain. The regression model was significant overall, F(5, 263) = 4.787, p < .001, and explained 8.3% of the variance in knowledge gain (R^2 = .083). An examination of the standardized regression coefficients showed that role-playing in particular had a significantly positive influence on self-assessed knowledge gains (β = .161, p = .029). In contrast, group work had a significantly negative influence (β = −.190, p = .007). The other methods (assessment, case studies, simulations) were not statistically significant. Overall, the model shows a moderate effect, pointing to the fact that not all interactive methods are equally effective with all groups and that students' might benefit less from group work than professionals.

Overall, while the use of interactive methods has a statistically significant influence on self-assessed knowledge gains of medical students, it is comparatively minor. Despite this, there is a consistent positive correlation. It can therefore be concluded that interactive methods play a supporting role in the learning process but are not the sole determinant of learning success for medical students.

For medical professionals, a linear regression showed that the number of interactive methods used was a significant predictor of participants' self-perceived knowledge gains after attending the training, F(1, 194) = 4.91, p = .028. However, the explained variance was small (R^2 = .025). In contrast to doctors, where no significant relation could be determined, a significant positive correlation was found for nurses, F(1, 68) = 7.168, p = .009. The model explained 9.5% of the variance (R^2 = .095), and the regression coefficient was significant (B = .539; p = .009). Interactive methods appear to have a positive effect on the subjectively perceived increase in knowledge after training among nurses, but not among doctors. An additional linear regression, that looked at the number of interactive methods as a predictor for results of the multiple-choice questions showed no significant results – neither in general, nor specifically for doctors or nurses.

High average scores were achieved not only in terms of the relevance of the training for medical studies and for working with victims of domestic violence in hospitals, but also with regard to their applicability. 79% of the medical students surveyed (n=269) chose a scale value of 8-10 when asked how strongly they agreed with the statement that the contents of the VIPROM-training relate to other areas of their university studies (Tab. 3), with an average mean value of 8,48. Strong agreement (mean value 8,78) was also reported for the statement that the training provided important content and training, which was lacking from other university course work. When looking at the data from six months after the training (Q3, n=119), again this positive training feedback prevails (M=8,31, df M Q2-Q3=-0,17).

Table 3. Relation to university studies (medical students; Q2, n=269)

Item content	Disagree/agree (1-10)	n	%
The content of the course related to other areas of my university studies.	1 = strongly disagree	4	1,5
	2	5	1,9
	3	4	1,5
	4	1	0,4
	5	2	0,7
	6	15	5,6
	7	25	9,3
	8	54	20,1
	9	45	16,7
	10 = strongly agree	114	42,4
	Total	269	100,0

Similarly, 81% of medical professionals (n=196) choose scale values between 8 and 10, strongly agreeing with the statement that the content of the training applied in their area of work – in total the mean value was 8,83 (Tab. 4). Six months later, medical professionals (n=134) reached a mean value of 8,11, signifying a decrease of the mean value (df M Q2-Q3) of 0,72. This slight decrease seems to be well within the range of what is to be an expected different between a survey directly after a training that was perceived as highly positive and elevating and the situation after six months, when everyday-difficulties might be gnawing at the positive view.

Table 4. Applicability of training content (medical professionals; Q2, n=196)

Item content	Disagree/agree (1-10)	n	%
I can apply the content of the training in my area of work.	1 = strongly disagree	0	
	2	1	0,5
	3	1	0,5
	4	1	0,5
	5	5	2,6
	6	8	4,1
	7	22	11,2
	8	33	16,8
	9	19	9,7
	10 = strongly agree	106	54,1
	Total	196	100,0

3.2.3. Open Comments on Training Quality

The data highlights that the VIPROM-trainings were well received by medical students and medical professionals with high mean values across all evaluated training aspects, like training structure, the expertise of trainers/lecturers or the didactic methods. Furthermore participants perceived a high impact of the trainings on their knowledge about domestic violence and their confidence to talk to patients about domestic violence.

Students and medical professionals were also given the opportunity to express positive remarks in regard to the training, as well as critical feedback and further ideas. Positive feedback given by medical students highlighted the comprehensive nature of the trainings and especially the plurality of didactic methods, enhancing the learning experience. The variety of chosen didactics and methods were perceived as well balanced, especially interactive didactics were repeatedly positively commented on, e.g. role plays or working with case studies that are practically orientated. Furthermore the open and friendly atmosphere and the creation of safe spaces during the trainings were commented on very positively, allowing students to freely express themselves and ask questions. Lastly, students praised the trainers, perceiving them as passionate and engaged about the topic, but also in regard to their competencies and their expertise. Regarding critical feedback and further ideas, students most often noted that more time is needed to address discussed topics more. Some students proposed more emphasis on “hands on” exercises, e.g. documentation, communication strategies with domestic violence patients or simulations, while others asked for more tailored training content to different areas of work (e.g. gynaecology or paediatrics). Overall,

participants expressed gratitude for the training multiple times, e.g. one participant summed it up in the following statement. “It was totally worth spending my weekend on this course!”

Similarly, medical professionals praised the broad variety of implemented didactics and training methods, allowing for engaging and rich trainings. Furthermore the practicability of training content was positively rated, supported by the utilisation of best practices from other countries – especially training content e.g. on guidelines for treatment of patients, documentation of domestic violence or skills to talk to patients about domestic violence were received positively and useful. Trainers were seen as highly qualified and competent to provide clear and effective trainings. As with medical students, participants praised the good atmosphere during the trainings, with fruitful and engaging group discussions. Training contents overall were described as very relevant and useful. Overall the training was perceived as focused and concise, well targeted on healthcare professionals and created a better understanding for the healthcare’s responsibility to address domestic violence. Focusing on critical feedback, medical professionals also proposed to allocate more time to trainings to allow more in-depth exploration of domestic violence and put a stronger emphasize on practical exercises and group discussions, while reducing theoretical content – for example it was proposed to discuss anonymised prior cases from participants, simultaneously putting more focus on the respective country context and pre-existing conditions. Furthermore some participants emphasised the need for ongoing training and regular updates to stay informed about new data and developments in the field. When asked for final feedback at the end of the survey, comments provided suggested to expand the training to include other groups of professionals to maximise its impact and expressed strong gratitude for the training opportunity. Some expressed the need for creating clear protocols for handling cases of domestic violence to help professionals better navigate these cases. To highlight the overall positive and productive feedback of medical professionals, we quote the following statement given by one participant: “After the training, I feel more confident and safer to discuss domestic violence and to act, if necessary.”

3.3. Self-assessment of Knowledge and Competencies

Participants’ were also asked to assess training effects using two questions (see Annexes 7.2 and 7.5):

1. After the course, I know more about domestic violence. (1-10)
2. How would you rate the impact of the course you just took on your knowledge? (1-10)

In Q2 medical students (n=269) on average rated the statement 9,2 that after the training they knew more about domestic violence, medical professionals (n=196) at 9,13. The impact of the training on their knowledge about domestic violence was rated at a mean value of 8,47 by medical students (n=266) and 8,63 by medical professionals (n=181). Six months later, medical students’ (n=119) rating of these items remained quite similar, with the average rating of knowledge gains (df M Q2-Q3: -0,21) and the impact of the training on their knowledge (df M Q2-Q3: -0,33) only very slightly decreased. For medical professionals a similar pattern emerged with regard to overall knowledge gains with the mean value decreasing by only half a point (df M Q2-Q3: -0,48), yet interestingly the perceived impact of the training being rated significantly lower with a decrease of over five points (df M Q2-Q3: -5,60) (Tab. 5). Interpretations of this finding are not quite clear – as we will show in the following –none of the other items show a similar decrease and some even seem to contradict it. One explanation might be that in hindsight – with a more sober outlook than directly after the very positive

training experience – medical professionals realised that a) they had already had quite some knowledge before the training and b) found that applying training contents still required a kind of “translation” from the training itself to everyday practice. These interpretations of course have to remain speculative at the moment as other data does not corroborate findings on this specific item.

Table 5. Perceived knowledge gains after training (1-10 scale; n=number of respondents, M=mean value; df M Q2-Q3=difference between mean values for Q2-Q3)

	Students					Professionals				
Item content	Q2 n	Q2 M	Q3 n	Q3 M	df M Q2-Q3	Q2 n	Q2 M	Q3 n	Q3 M	df M Q2-Q3
After the training, I know more about domestic violence.	269	9,20	119	8,99	-0,21	196	9,13	133	8,65	-0,48
How would you rate the impact of the training you just took part in on your knowledge?	266	8,47	120	8,14	-0,33	181	8,63	134	3,03	-5,60

In order to assess not only participants’ declarative knowledge gains, but also participants’ self-assessment of skills, they were asked whether they agreed to the statement that they felt “more confident talking to patients about domestic violence” after the training. On this question medical students’ (n=269) answers reached a mean value of 8,18 and medical professionals’ (n=194) of 8,79. Assessing changes in mean values after six months sees a stable result in medical students’ (df M Q2-Q3: 0,08) answers and a slight decrease in those of medical professionals (df M Q2-Q3: -0,58) (Tab. 6).

Table 6. Confidence in communication skills (1-10 scale; n=number of respondents, M=mean value; df M Q2-Q3=difference between mean values for Q2-Q3)

	Students					Professionals				
Item content	Q2 n	Q2 M	Q3 n	Q3 M	df M Q2-Q3	Q2 n	Q2 M	Q3 n	Q3 M	df M Q2-Q3
As a result of the training, I feel more confident talking to patients about domestic violence.	269	8,18	119	8,26	0,08	194	8,79	132	8,21	-0,58

Six months after the training, medical professionals additionally were asked to rate the training impact in regard to their work with patients. Results show high mean values across all three statements, meaning that medical professionals attested a notable impact of the training on their self-assurance in their approach and communication with victims of DV (n=133, M=8,39), positive changes in their approach and communication with victims of DV (n=133, M=8,33) and lastly on their efforts in driving forward changes in their area of work that benefit victims of DV (n=116, M=8,44) (Tab. 7). These responses can be interpreted as a strong indication of a sustainable effect of VIPROM-trainings and their ability to engender institutional change.

Table 7. Training impact perceived after six months (1-10 scale; medical professionals; Q3; n=number of respondents; M=mean value)

Item content	Q3 n	Q3 M
The training has reassured me in some aspects of my approach and communication with victims of domestic violence.	133	8,39
The training has positively changed some aspects of my approach and communication with victims of domestic violence.	133	8,33
The training supports my efforts in driving forward changes in my area of work that benefit victims of domestic violence.	116	8,44

Finally, there was similarly strong agreement among both medical students and medical professionals regarding the statement that the training made it easier to raise the topic of domestic violence with colleagues at the hospital/university – students (n=269) rated this at a mean value of 8,42, while medical professionals (n=193) gave an average rating of 8,88. Six months later mean values only slightly differ for both groups.

3.3.1. Satisfaction, Knowledge Gains and Applicability

To assess whether there is a correlation between participants' satisfaction with the training and their self-assessed increase in knowledge on the topic of domestic violence bivariate correlations were first performed, followed by a linear regression analysis. For medical students, the correlation analysis (Spearman's rho) revealed a significant positive correlation between the perceived quality of the training and the self-assessed increase in knowledge attributed to the training ($\rho = .487$, $p < .001$), i.e. medical students, who gave the overall quality of the training higher ratings also tended to report greater knowledge gains. For further testing, a linear regression analysis was performed using satisfaction with the training as the predictor variable and knowledge gain as the criterion variable. The regression model was significant overall ($F(1, 265) = 111.91$, $p < .001$) and explained 29.7% of the variance in knowledge gain ($R^2 = .297$). The predictor training satisfaction significantly and positively predicted knowledge gain ($B = 0.563$, $SE = 0.053$, $\beta = .545$, $t = 10.58$, $p < .001$). A follow-up analysis was done on Q3-data in order to determine whether the relationship between training quality and perceived knowledge gains persisted over time. The correlation analysis (Spearman's rho) again revealed a moderate, positive, and statistically significant relationship between the perceived

quality of the training and self-reported knowledge gains, ρ (119) = .479, p < .001. Participants who continued to rate the training quality also reported greater knowledge retention and perceived learning effects after six months.

A subsequent linear regression analysis confirmed this finding. Perceived quality significantly predicted knowledge gain, F(1,117) = 46.68, p < .001, explaining 28.5% of the variance (R^2 = .285). The regression coefficient was positive and statistically significant (B = 0.503, SE = 0.074, β = .534, t = 6.83, p < .001), indicating that higher quality ratings were associated with higher sustained knowledge gains. These follow-up results suggest that the influence of training quality on perceived knowledge gain remains stable over time, even several months after participation. This highlights that participants' experience of the training has a lasting impact on their learning outcomes. Focusing on improving the perceived quality of training programs through careful tailoring of didactic methods therefore does not only lead to higher satisfaction, but can also be an effective approach to promoting long-term knowledge retention among medical students in the field of domestic violence education.

A Spearman correlation was calculated for medical professionals to examine the relationships between quality, subjectively perceived increase in knowledge, and the applicability of the content to the field of work as assessed by participants directly after the training. All correlations were positive and significant at the 0.01 level. There was a moderate correlation between perceived training quality and knowledge gains (ρ = .373; p < .001). Training quality correlated weakly with the applicability of the content (ρ = .221; p = .002). Knowledge gain was moderately correlated with the applicability of the content in the participants' own work context (ρ = .465; p < .001). The results show that the higher the quality of the training was rated, the more likely medical professionals were to report an increase in their knowledge of domestic violence and the ability to apply the content in their everyday work. A linear regression analysis was performed to investigate whether the perceived quality of the training could predict the subsequent applicability of the training content in everyday work. The model was statistically significant, F(1, 194) = 7.91, p = .005, and explained 3.9% of the variance in applicability (R^2 = .039). The perceived training quality was a significant predictor of the applicability of the content (β = .198, p = .005). A second linear regression was conducted to examine whether the perceived knowledge gain after the training predicts the applicability of the training content to participants' area of work. The model was statistically significant, F(1, 193) = 43.96, p < .001, indicating that knowledge gain significantly predicts application of training contents in medical professionals respective areas of work. The model explained approximately 18.6% of the variance in application scores (R^2 = .186). The regression coefficient for knowledge gain was B = 0.469, p < .001, suggesting that for every one-point increase in perceived knowledge gain, the application rating increased by 0.469 points on average. The standardized beta coefficient (β = .431) indicates a moderate effect size. These findings suggest that greater perceived knowledge gain from the training is associated with higher perceived applicability of the training content in practice.

The same linear regression analyses for doctors were statistically significant as well. The model that examined whether the perceived quality of the training predicted the applicability of the training content in doctors' areas of work, was statistically significant, F(1, 83) = 4.76, p = .032, indicating that the perceived quality of the training significantly predicted the extent to which doctors reported applying the training content in their field of work. The model explained approximately 5.4% of the variance in application scores (R^2 = .054). The regression coefficient for training quality was positive and significant (B = 0.257, SE = 0.118, β = .233, t = 2.181, p = .032), suggesting that higher perceived quality of the training was associated with

greater reported applicability of its content in the doctors' professional context. However, the effect size was small, indicating that while perceived training quality contributes to how well doctors can apply the content in their work other factors likely play a more substantial role in determining practical implementation. The second model was statistically significant as well ($F(1, 83) = 19.39$, $p < .001$), indicating that knowledge gain is a significant predictor of applicability. The model explained approximately 18.9% of the variance in application scores ($R^2 = .189$). The regression coefficient for knowledge gain was significant ($B = 0.393$, $SE = 0.089$, $\beta = .435$, $t = 4.403$, $p < .001$). This suggests that higher reported knowledge gain after the training was associated with higher perceived applicability of the training content in the doctors' professional context.

For nurses the regression models produced mixed results. The first linear regression analysis was conducted to examine whether the perceived quality of the training predicted the applicability of the training content among nurses. The model did not reach statistical significance, $F(1, 67) = 2.68$, $p = .107$, and explained only 3.8% of the variance in application scores ($R^2 = .038$). The regression coefficient for perceived training quality was positive but not significant ($B = 0.363$, $SE = 0.222$, $\beta = .196$, $t = 1.636$, $p = .107$). Although the direction of the effect suggests that higher perceived training quality was associated with greater applicability of the content in practice, the relationship was weak and statistically non-significant. This indicates that, for nurses, perceived training quality alone was not a reliable predictor of how applicable they found the training content in their professional context. The second regression model analysing whether the perceived knowledge gains on domestic violence predicted the applicability in nurses area of work was statistically significant, $F(1, 67) = 16.21$, $p < .001$, indicating that the knowledge gains after the training predicts the applicability of the training contents for nurses. The regression model explained approximately 19.5% of the variance ($R^2 = .195$), with a moderate positive correlation between the predictor and outcome variable ($R = .441$). The unstandardized regression coefficient (B) for knowledge gains after the training was 0.496 ($SE = 0.123$), and the standardized coefficient (β) was .441, indicating a moderate effect size. This predictor was statistically significant ($t = 4.03$, $p < .001$), suggesting that increases in knowledge after training are associated with higher levels of applicability for their areas of work. Our results can be understood to show that the VIPROM-trainings managed to establish high satisfaction with training quality and that this translates to participants (self-assessed) knowledge gains as well as practical applicability.

At the six-month follow-up, the relationships between perceived training quality, self-assessed knowledge gain, and applicability of the training content remained positive and significant, indicating that the training effects persisted over time. A moderate correlation was found between training quality and perceived knowledge gain ($\rho = .408$, $p < .001$), and a weaker but still significant correlation emerged between training quality and applicability of the content ($\rho = .256$, $p = .003$). Knowledge gains showed a moderate correlation with applicability ($\rho = .466$, $p < .001$), suggesting that participants who retained more knowledge continued to perceive the training content as more relevant to their professional context. A linear regression analysis using perceived training quality as the predictor and applicability as the outcome variable was statistically significant ($F(1, 131) = 6.198$, $p = .014$), explaining 4.5% of the variance in applicability ($R^2 = .045$). The regression coefficient was positive and significant ($B = 0.402$, $SE = 0.161$, $\beta = .213$, $t = 2.49$), indicating that higher perceived training quality continued to be associated with greater perceived applicability of the training content. Although the explained variance remained small, the result confirms that participants who evaluated the training as higher in quality were more likely to report that they could apply the learned material in practice six months later. A second linear regression analysis was conducted to assess whether

perceived knowledge gains predicted the applicability of the training content six months after the training. The model was statistically significant ($F(1, 131) = 24.510$, $p < .001$) and explained 15,8% of the variance in applicability ($R^2 = .158$). The regression coefficient was significant ($B = 0.456$, $SE = 0.092$, $\beta = .397$, $t = 4,95$), showing a moderate positive relationship between knowledge gain and the perceived applicability of the content. Compared to the immediate post-training results, the strength of the relationship between training quality and applicability remained stable, while the predictive power of perceived knowledge gain decreased slightly (from $R^2 = .186$ to $R^2 = .158$) but remained moderate in magnitude. These findings suggest that both training quality and knowledge gains continued to play a meaningful role in determining how well medical professionals could apply the training content in their daily work half a year later. The results indicate that the training had a lasting effect on the perceived transfer of learning into practice.

Looking specifically at doctors, the regression model predicting applicability from perceived training quality was statistically significant, $F(1, 42) = 5.54$, $p = .023$, explaining 11.6% of the variance in applicability ($R^2 = .116$). The regression coefficient was positive and significant ($B = 0.532$, $SE = 0.226$, $\beta = .341$, $t = 2.35$), indicating that higher perceived training quality was associated with greater applicability of the training content in doctors' professional practice. Compared to the immediate post-training assessment, both the explained variance and the effect size increased, suggesting a strengthening of the link between perceived quality and practical application over time. The second model, assessing the predictive effect of perceived knowledge gain on applicability, was also statistically significant, $F(1, 43) = 21,90$, $p < .001$, explaining 33.7% of the variance in applicability ($R^2 = .337$). The regression coefficient was significant and positive ($B = 0.658$, $SE = 0.141$, $\beta = .581$, $t = 4.68$), indicating a strong relationship between knowledge gains and the subsequent applicability of the training content in their area of work. In comparison to the results immediately after the training, the association between knowledge gains and applicability became markedly stronger (R^2 increasing from .189 to .337), suggesting that perceived learning outcomes had an enduring and even growing impact on the practical integration of training content over time. These findings indicate that, for doctors, both perceived quality and knowledge gain continued to be important predictors of applicability six months after the intervention, with knowledge gain emerging as the more powerful long-term determinant of training transfer.

For nurses, the linear regression analysis investigating whether perceived training quality predicted the applicability of the training content in their area of work was not statistically significant, $F(1, 43) = 0.443$, $p = .509$, and explained only 1.0% of the variance in applicability scores ($R^2 = .010$). The regression coefficient for perceived training quality was positive but not significant ($B = 0.229$, $SE = 0.344$, $\beta = .101$, $t = 0.665$). Other statistical tests provided similar results showing small positive but non-significant correlations that do now allow for a clear interpretation.

3.3.2. Self-assessment Before and After Training

The second approach to measuring knowledge gains was to compare participants' self-assessment of knowledge and skills before and after the VIPROM-trainings. In the following we dive deeper into this data.

The questions included 10-point scales for self-in relation to various skills and knowledge areas. The data is evaluated in the form of mean values across the different survey dates (Q1,

Q2, Q3) in order to analyse the impact of the VIPROM-trainings. Anticipating a more detailed look at the data it can be stated that across all self-assessment items regarding knowledge and competencies of trainees, training effects are impressively stable after six months, hardly diverging from mean values directly after the training (Q2).

When asked how they would rate their knowledge of domestic violence in general, medical students (n=270) achieved a mean value of 5,33 before the training (Q1) and a mean value of 7,59 after the training (Q2, n=266) (df M Q1-Q2: 2,26). Medical professionals (n=168) had a mean value of 5,79 before the training (Q1) and a mean value of 7,55 after the training (Q2, n=177) (df M Q1-Q2: 1,76). Mean values remained relatively stable after six months (Q3) for both groups (Tab. 8).

Table 8. Self-assessment of general knowledge on DV (1-10 scale; Q1-Q3; n=number of respondents; M=mean value; df M=difference in mean values)

Item: How would you rate your knowledge of domestic violence?															
Students								Professionals							
Q1 n	Q1 M	Q2 n	Q2 M	Q3 n	Q3 M	df M Q1-Q2	df M Q2-Q3	Q1 n	Q1 M	Q2 n	Q2 M	Q3 n	Q3 M	df M Q1-Q2	df M Q2-Q3
270	5,33	266	7,59	120	7,65	2,26	0,06	168	5,79	177	7,55	134	7,69	1,76	0,14

In addition to a general assessment of knowledge, specific areas were surveyed, such as knowledge of the most common forms of and main risk factors for domestic violence knowledge of relevant guidelines, laws, and regulations or about potential barriers in the healthcare system. Further questions related directly to medical professionals' agency like knowledge of risk assessment tools or of the working of the violence protection system, i.e. counselling and support services for victims. At Q1 mean values for these aspects ranged from just under 3 among students to a little above 6 points. As expected, medical professionals rated their knowledge a bit higher than medical students already before the training, therefore the gains perceived are also less steep.

Across all aspects on average training effects (df M Q1-Q2) of around two to just under four points can be observed for both medical students and medical professionals. The greatest training effects among medical students, in terms of the difference in mean values between the first and second survey, were found with regard to knowledge about the violence protection system (Q1: 2.91, Q2: 6,85, df M Q1-Q2: 3,94), relevant guidelines, laws, and regulations when working with victims of domestic violence (Q1: 3,65, Q2: 7,5, df M Q1-Q2: 3,85) and tools to identify domestic violence and assess risks (Q1: 4,12, Q2: 7,86, df M Q1-Q2: 3,74).

The strongest training effects among medical professionals were in terms of knowledge about tools to identify domestic violence and assess risks (Q1: 4,66, Q2: 7,78, df M Q1-Q2: 3,12), barriers in the healthcare system that make it difficult for people to talk about domestic violence (Q1: 5,62, Q2: 8,55, df M Q1-Q2: 2,93) and, again relevant guidelines, laws, and regulations when working with victims of domestic violence (Q1: 4,98, Q2: 7,61, df M Q1-Q2: 2,63).

For Q3 mean values remained stable with maximum changes between +0,34 and -0,30 for medical students as well as medical professionals (df M Q2-Q3). These are too small to allow for interpretation as they might even be attributed to differences between the samples (Tab 9.).

Table 9. Self-assessment of knowledge on aspects of DV (1-10 scale; Q1-Q3; n=number of respondents, M=mean values; df M=difference in mean values)

	Students								Professionals							
Item content	Q1 n	Q1 M	Q2 n	Q2 M	Q3 n	Q3 M	df M Q1-Q2	df M Q2-Q3	Q1 n	Q1 M	Q2 n	Q2 M	Q3 n	Q3 M	df M Q1-Q2	df M Q2-Q3
I know the most common forms of domestic violence.	271	6,23	266	8,67	119	8,39	2,44	-0,28	196	6,56	197	8,61	132	8,38	2,05	-0,23
I know about the main risk factors for domestic violence.	271	5,70	266	8,50	119	8,36	2,80	-0,14	196	5,86	196	8,58	132	8,28	2,72	-0,30
I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	267	3,65	265	7,50	118	7,72	3,85	0,22	194	4,98	196	7,61	128	7,70	2,63	0,09
I have the tools to identify domestic violence and assess risks.	271	4,12	266	7,86	119	7,83	3,74	-0,03	195	4,66	197	7,78	131	7,73	3,12	-0,05
I am aware of barriers in the healthcare system, which makes it difficult for people to talk about domestic violence.	270	4,99	265	8,33	119	8,48	3,34	0,15	196	5,62	197	8,55	132	8,38	2,93	-0,17
I know about services, advice and support centres for victims of domestic violence in my area.	271	3,87	266	7,35	119	7,69	3,48	0,34	195	5,15	196	8,02	132	7,73	2,87	-0,29
I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	270	2,91	265	6,85	118	7,07	3,94	0,22	188	3,90	196	7,30	132	7,15	3,40	-0,15

10-point self-assessment questions were also asked with a focus on practical – for example, recognising indicators of domestic violence, feeling competent to communicate with victims, knowing screening questions or referral procedures to specialized counselling and support services. Since medical students and medical professionals were asked different questions, the results are discussed separately. For medical students, it should be noted that domestic violence had mostly not been a relevant topic in their studies before the VIPROM-training, with the respective question only receiving 3,7 out of 10 points on average. This also explains the low ratings students gave their skills before the training (Q1) – with the lowest mean values for knowledge of referral procedures to specialized counselling and support services (M=2,83) and for the ability to perform documentations of injuries caused by domestic violence that can be used in court (M=2,43).

Looking at the training effects, i.e. the mean values across the different surveys, a significant increase in the mean values (df M Q1-Q2) of around 3,5 to just under 5 points can be observed. The greatest training effect is seen in knowledge about screening questions about domestic violence (Q1: 3,11, Q2: 8,04, df M Q1-Q2: 4,93) and knowledge about referral procedures to specialized counselling and support services (Q1: 2,83, Q2: 7,48, df M Q1-Q2: 4,65).

Again mean values for Q3 remain nearly unchanged hinting at a stable trainings effect (df M Q2-Q3) (Tab. 10).

Table 10. Self-assessment of skills (1-10 scale; medical students; Q1-Q3; n=number of respondents; M=mean value; df M=difference in mean values)

Item content	Q1 n	Q1 M	Q2 n	Q2 M	Q3 n	Q3 M	df M Q1-Q2	df M Q2-Q3
Dealing with domestic violence has been a relevant topic in my studies to date.	270	3,73						
I know indicators for domestic violence.	270	4,84	266	8,55	119	8,23	3,71	-0,32
I feel competent to communicate with victims of domestic violence.	271	3,85	266	7,44	119	7,45	3,59	0,01
I know examples of screening questions about domestic violence.	267	3,11	266	8,04	119	7,78	4,93	-0,26
I know referral procedures to specialised counselling and support services.	270	2,83	266	7,48	119	7,52	4,65	0,04
I can perform documentations of injuries caused by domestic violence that can be used in court.	267	2,43	266	6,76	119	6,84	4,33	0,08

Compared to medical students, the mean values of medical professionals with regards to knowledge and competencies on domestic violence prior to VIPROM-training (Q1) are higher, averaging between 3,4 and 5,7. The lowest mean value was achieved for the competency to create documentation of injuries caused by domestic violence that can be used in court (M=3,39). As this is a core competency of doctors in relation to DV this finding once more underscores the necessity of well-adapted trainings. The greatest training effect, was again achieved in relation to knowledge of when and how to refer (potential) victims of domestic violence to further/specialised counselling and support services (Q1: 4,59, Q2: 7,74, df M Q1-Q2: 3,15) and the competence to carry out a risk assessment and derive measures from it (Q1: 4,37, Q2: 7,48, df M Q1-Q2: 3,11) (Tab. 11).

Table 11. Self-assessment of skills (1-10 scale; medical professionals; Q1-Q3; n=number of respondents; M=mean value; df M=difference in mean values)

Item content	Q1 n	Q1 M	Q2 n	Q2 M	Q3 n	Q3 M	df M Q1-Q2	df M Q2-Q3
It is easy for me to talk to patients about domestic violence.	192	5,65	194	7,52	130	7,53	1,87	0,01
I recognise indicators for domestic violence.	195	5,46	197	8,18	131	8,01	2,72	-0,17
I can carry out a risk assessment and derive measures from it.	194	4,37	196	7,48	130	7,35	3,11	-0,13
I routinely include screening questions about domestic violence in my conversations with patients.	190	4,19	192	6,45	127	6,55	2,26	0,10
I know when and how to refer (potential) victims of domestic violence to further/specialized counselling and support services.	193	4,59	196	7,74	129	7,53	3,15	-0,21
I have practice in creating documentation of injuries caused by domestic violence that can be used in court.	194	3,39	195	5,87	130	5,72	2,48	-0,15

The data impressively show the need for trainings on the topic of domestic violence for both medical students and medical professionals alike – dealing with domestic violence has not been a prominent topic in the studies of most medical students before participating in the VIPROM-training. In general it can be stated that the VIPROM-curriculum managed to convey its contents very successfully. Mean values for self-assessed competencies have increased across all items for medical students and medical professionals alike, showing a consistent effect in subjectively perceived gains in knowledge as well as skills. Furthermore mean values after six months hardly diverge from data collected directly after the trainings, indicating that the learning effects were stable.

3.4. Multiple-Choice Questions

In order to measure knowledge gains somewhat more objectively there were four multiple-choice questions, each with four possible answers:

MC1. Which individuals/groups are victims or perpetrators of domestic violence?

MC2. In which of the following situations is there an increased risk of domestic violence?

MC3. Under what circumstances should healthcare professionals ask patients about domestic violence?

MC4. What should be considered when treating domestic violence? How should medical professionals deal with the situation?

The answer options were weighted differently according to difficulty, with each MC question resulting in maximal six points, in case all correct answers and none of the wrong ones were checked, and the lowest possible number of minus six points, in case all wrong answers – and only these – were checked. In case all answers, correct as well as incorrect, were chosen, the total score amounted to zero. The MC questions and answer options were formulated on the basis of the VIPROM-training platform. Comparisons of results were used to examine changes in trainees' knowledge over time. The evaluation focused on two aspects: (1) To what extent do mean values (range -6 to +6) for points reached for the MC questions change between surveys? (2) To what extent does the response behaviour change in relation to the 16 options for answer over time?

With regard to the first question, it can be noted that the mean values for all four MC questions increased without exception after the training (Q2) – this applies equally to medical students (MC1 +0,55; MC2 +1,59; MC3 +0,50; MC4 +0,99) and medical professionals (MC1 +0,34; MC2 +1,05; MC3 +0,76; MC4 +0,77). The training has therefore led to an increase in knowledge among the trainees. Medical students showed slightly higher gains across three of the four MC questions – this result is in accordance with the generally lower knowledge of medical students before training which allowed for bigger gains in comparison to medical professionals (Tab. 12).

When taking into account mean values for all MC questions combined after six months (Q3), data shows a slight decrease for both medical students between Q2 and Q3 (df M Q2-Q3: -0,97) and medical professionals (df M Q2-Q3: -0,55) (Tab. 13). However, this result needs to be interpreted cautiously, because of the different sample sizes. Still it indicates a strong training effect overall in regard to measurable knowledge gains after the VIPROM-trainings.

Table 12. Mean values scored on individual multiple-choice-questions (max. +6; Q1-Q3; n=number of respondents; M=mean value; df M=diference in mean values)

	Students									Professionals								
Multiple-Choice Question	**Q1 n**	**Q1 M**	**Q2 n**	**Q2 M**	**Q3 n**	**Q3 M**	**df M Q1-Q2**	**df M Q1-Q3**	**df M Q2-Q3**	**Q1 n**	**Q1 M**	**Q2 n**	**Q2 M**	**Q3 n**	**Q3 M**	**df M Q1-Q2**	**df M Q1-Q3**	**df M Q2-Q3**
Which persons/groups are victims or perpetrators of domestic violence?	272	2,90	263	3,45	115	3,48	0,55	0,58	0,03	196	3,42	197	3,76	130	3,74	0,34	0,32	-0,02
In which of the following situations is there an increased risk of domestic violence?	272	2,90	263	4,49	115	3,73	1,59	0,83	-0,76	196	3,81	197	4,86	130	4,82	1,05	1,01	-0,04
Under what circumstances should healthcare professionals ask patients about domestic violence?	270	1,17	263	1,67	115	1,75	0,50	0,58	0,08	197	2,54	197	3,30	129	3,46	0,76	0,92	0,16
What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?	270	3,67	262	4,66	114	4,42	0,99	0,75	-0,24	197	3,94	196	4,71	128	4,15	0,77	0,21	-0,56

Table 13. Mean values scored across all multiple-choice-questions (max. +24; Q1-Q3; n=number of respondents; M=mean value; df M=diference in mean values)

	Students						Professionals					
	Q1	Q2	Q3	df M Q1-Q2	df M Q1-Q3	df M Q2-Q3	Q1	Q2	Q3	df M Q1-Q2	df M Q1-Q3	df M Q2-Q3
MC SUM	272	262	115				198	196	130			
MC M	10,60	14,31	13,34	3,71	2,74	-0,97	13,61	16,63	16,08	3,02	2,47	-0,55

A closer look at changes in response behaviour to the MC questions is instructive. The questionnaire survey dates (Q1-Q2) were used to examine how often individual response options were selected and to what extent training effects could be observed. To this end, individual MC responses are examined below to determine whether the correct answer(s) were selected more frequently, i.e., whether a positive training effect could be observed. In order to take into account the different sample sizes, the frequencies of the selected responses were expressed as a percentage of the respective sample size. With regard to medical students, the strongest training effect (MC2, df % Q1-Q2: 40,8%) was observed in the correctly formulated statement that pregnancies pose an increased risk of domestic violence (MC2, % Q1: 48,5%, % Q2: 89,4%). This positive training effect slightly decreased after six months (df % Q2-Q3: -2,4). Another significant positive training effect (MC3, df % Q1-Q2: 25,7%) was observed for the correctly formulated statement that all patients should routinely be asked about DV (MC3, % Q1: 23,3%, % Q2: 49%) – six months later this training effect lessened (df % Q2-Q3: -6,4), indicating that the importance of routine screening when dealing with patients could be stressed even more in VIPROM-trainings. Positive training effects were also observed in the following statements: in the incorrectly formulated statement that it is acceptable for relatives/children of patients to translate for them (MC4, % Q1: 25,9%, Q2: 13,7%, df % Q1-Q2: -12,2%, df % Q2-Q3: 1,2%), in the similarly incorrectly formulated statement that there is an increased risk of domestic violence at discos/while clubbing (MC2, % Q1: 36,8%, % Q2: 27%, df % Q1-Q2: -9,8%, df % Q2-Q3: 0,8%) and the positively worded statement that if patients are not willing to talk about the situation, this should be accepted (MC4, % Q1: 69,6%, % Q2: 80,9%, df % Q1-Q2: 11,3%) – data from six months later showed a decrease in training effect by over 5%, suggesting the possibility to put more emphasis on this issue (df % Q2-Q3: -5,5). Additional positive training effects occurred in the following statements: the positively worded statement that there is no “typical victim” (MC1, % Q1: 86%, % Q2: 96,6%, df % Q1-Q2: 10,5%, df % Q2-Q3: 0,8%), and the incorrectly formulated statement that domestic violence is a problem of backward cultures (MC1, % Q1: 17,6%, % Q2: 11%, df % Q1-Q2: -6,6%) – data from six months later showed a slight additional improvement in response rates to this statement (df % Q2-Q3: -4,1%).

Three statements had a negative training effect on medical students, meaning that correctly formulated statements were selected less frequently and incorrectly formulated statements were selected more frequently in Q2. In this context, there is a negative training effect for the incorrectly formulated statement that direct questions about DV can have traumatising effects and should therefore be avoided (MC3, % Q1: 24,8%, % Q2: 49,4%, df % Q1-Q2: 24,6%) – while the negative training effect persists after six months, it has lessened a bit (df % Q2-Q3: -14,6%, df % Q1-Q3: 10%). This seems especially relevant as this is a common misconception that needs to be addressed clearly in all VIPROM-trainings (just as it is already clearly addressed in the learning modules). It is possible that students over-interpreted the wording of the questions (reading “direct” as “brutal” or “insensitive”) or just shied away from the word “trauma”. Very slight negative training effects were also seen with other questions, but differences remained too small to allow for comprehensive interpretations. The same holds true for some changes in students’ answers when comparing Q2 and Q3, which are in all probability not an effect of the training (Tab. 14).

Similar trends regarding individual MC responses are evident for medical professionals. The greatest positive training effects can be seen in the correctly formulated statements that there is an increased risk of domestic violence during pregnancy (MC2, % Q1: 68,9%, % Q2: 96,4%, df % Q1-Q2: 27,6%) – with a slight decrease in training effect six months later (df % Q2-Q3: -4,9); followed by the statement that all patients should routinely be asked about domestic

violence (MC3, % Q1: 46,2%, % Q2: 67,5%, df % Q1-Q2: 21,3%) – again with a slight decrease in training effect (df % Q2-Q3: -5,5). Further positive training effects relate to the correctly formulated answers that perpetrators of violence are often charming (MC1, % Q1: 47,4%, % Q2: 60,9%, df % Q1-Q2: 13,5%), that if patients are not willing to talk about their situation, this should be accepted (MC4, % Q1: 70,6%, % Q2: 84,7%, df % Q1-Q2: 14,1%) and the incorrectly formulated statement that there is an increased risk of domestic violence at discos/clubbing (M2, % Q1: 27,6%, % Q2: 17,8%, df % Q1-Q2: -9,8%). Across all three statements, training effects decreased by some percentage points, with positive training effects persisting after six months (Tab. 15).

A number of statements for both groups showed only little to no training effects – this is mainly to be explained as a consequence of the MC-format and the fact that these statements have been correctly identified as true or false by a vast majority of participants from the start.

These results – albeit covering only a fraction of the VIPROM-content – suggest that the trainings were extremely successful in conveying some highly important knowledge as well as good practices, e.g. in relation to the necessity of universal DV screening in hospitals. Across both medical students and medical professionals, responses to MC-questions showed consistent training effects.

Results on one question asking specifically about stereotypical images of perpetrators and victims of DV also show that harmful stereotypes can be mitigated in training – thereby showcasing the importance of the respective content and of a culturally sensitive approach. But training gains on average notwithstanding, they also showed that such stereotypes can be persistent among *some* participants and therefore might warrant even more attention and time during trainings especially when dealing with experienced professionals. An equal argument can be made about knowledge about the relevance of gender inequalities for understanding DV.

Table 14. Percentage of participants selecting specific MC-answers (medical students; Q1-Q3; T/F=true/false; n=number of respondents, %=share of respondents picking that number in % of total respondents for the question; df% changes in shares of respondents)

Answer choices to MC-Question 1	T/F	Q1 n=272	Q1 %	Q2 n=263	Q2 %	Q3 n=115	Q3 %	df % Q1-Q2	df % Q1-Q3	df % Q2-Q3
There is no "typical victim" - people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	t	234	86,0	254	96,6	112	97,4	10,5	11,4	0,8
DV is often the result of gender specific inequalities and therefore mainly affects women and girls.	t	185	68,0	185	70,3	59	51,3	2,3	-16,7	-19,0
Perpetrators of violence are often charming and friendly in demeanour.	t	119	43,8	102	38,8	53	46,1	-5,0	2,3	7,3
DV is a problem of backward cultures.	f	48	17,6	29	11,0	8	7,0	-6,6	-10,7	-4,1
Answer choices to MC-Question 2	**T/F**	**Q1 n=272**	**Q1 %**	**Q2 n=263**	**Q2 %**	**Q3 n=115**	**Q3 %**	**df % Q1-Q2**	**df % Q1-Q3**	**df % Q2-Q3**
Increased risk of DV during pregnancy.	t	132	48,5	235	89,4	100	87,0	40,8	38,4	-2,4
Increased risk of DV during and after a separation or divorce.	t	259	95,2	261	99,2	101	87,8	4,0	-7,4	-11,4
Increased risk of DV during university.	f	28	10,3	31	11,8	26	22,6	1,5	12,3	10,8
Increased risk of DV at a disco, clubbing or similar events.	f	100	36,8	71	27,0	32	27,8	-9,8	-8,9	0,8

Answer choices to MC-Question 3	T/F	Q1 n=270	Q1 %	Q2 n=263	Q2 %	Q3 n=115	Q3 %	df % Q1-Q2	df % Q1-Q3	df % Q2-Q3
All patients should routinely be asked about DV.	t	63	23,3	129	49,0	49	42,6	25,7	19,3	-6,4
Direct questions about DV can have a trauma-tising effect and should therefore be avoided.	f	67	24,8	130	49,4	40	34,8	24,6	10,0	-14,6
Patients with conspicuous injuries or behaviour should be asked about DV, regardless of the reason for their visit.	t	248	91,9	229	87,1	91	79,1	-4,8	-12,7	-7,9
Private issues should only be addressed if patients themselves indicate relationship problems.	f	15	5,6	15	5,7	5	4,3	0,1	-1,2	-1,4
Answer choices to MC-Question 4	**T/F**	**Q1 n=270**	**Q1 %**	**Q2 n=263**	**Q2 %**	**Q3 N=115**	**Q3 %**	**df % Q1-Q2**	**df % Q1-Q3**	**df % Q2-Q3**
It is not ideal, but acceptable, if relatives or children of the patient translate.	f	70	25,9	36	13,7	17	14,9	-12,2	-11,0	1,2
It is important not to enter into the conversation with preconceptions about victims and perpetrators.	t	227	84,1	236	90,1	102	89,5	6,0	5,4	-0,6
If an accompanying person is present, he/she should be included in the conversation.	f	15	5,6	5	1,9	3	2,6	-3,6	-2,9	0,7
If patients are not willing to talk about the situation, this should be accepted.	t	188	69,6	212	80,9	86	75,4	11,3	5,8	-5,5

Table 15. Percentage of participants selecting specific MC-answers (medical professionals; Q1-Q3; T/F=true/false; n=number of respondents, %=share of respondents picking that number in % of total respondents for the question; df% changes in shares of respondents))

Answer choices to MC-Question 1	T/F	Q1 n=196	Q1 %	Q2 n=197	Q2 %	Q3 N=130	Q3 %	df % Q1-Q2	df % Q1-Q3	df % Q2-Q3
There is no "typical victim" - people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	t	189	96,4	193	98,0	129	99,2	1,5	2,8	1,3
DV is often the result of gender specific inequalities and therefore mainly affects women and girls.	t	116	59,2	117	59,4	75	57,7	0,2	-1,5	-1,7
Perpetrators of violence are often charming and friendly in demeanour.	t	93	47,4	120	60,9	69	53,1	13,5	5,6	-7,8
DV is a problem of backward cultures.	f	21	10,7	20	10,2	10	7,7	-0,6	-3,0	-2,5
Answer choices to MC-Question 2	**T/F**	**Q1 n=196**	**Q1 %**	**Q2 n=197**	**Q2 %**	**Q3 N=130**	**Q3 %**	**df % Q1-Q2**	**df % Q1-Q3**	**df % Q2-Q3**
Increased risk of DV during pregnancy.	t	135	68,9	190	96,4	119	91,5	27,6	22,7	-4,9
Increased risk of DV during and after a separation or divorce.	t	189	96,4	182	92,4	117	90,0	-4,0	-6,4	-2,4
Increased risk of DV during university.	f	21	10,7	18	9,1	12	9,2	-1,6	-1,5	0,1
Increased risk of DV at a disco, clubbing or similar events.	f	54	27,6	35	17,8	15	11,5	-9,8	-16,0	-6,2

Answer choices to MC-Question 3	T/F	Q1 n=197	Q1 %	Q2 n=197	Q2 %	Q3 N=129	Q3 %	df % Q1-Q2	df % Q1-Q3	df % Q2-Q3
All patients should routinely be asked about DV.	t	91	46,2	133	67,5	80	62,0	21,3	15,8	-5,5
Direct questions about DV can have a traumatising effect and should therefore be avoided.	f	22	11,2	37	18,8	13	10,1	7,6	-1,1	-8,7
Patients with conspicuous injuries or behaviour should be asked about DV, regardless of the reason for their visit.	t	168	85,3	174	88,3	103	79,8	3,0	-5,4	-8,5
Private issues should only be addressed if patients themselves indicate relationship problems.	f	19	9,6	26	13,2	6	4,7	3,6	-5,0	-8,5
Answer choices to MC-Question 4	**T/F**	**Q1 n=197**	**Q1 %**	**Q2 n=196**	**Q2 %**	**Q3 N=128**	**Q3 %**	**df % Q1-Q2**	**df % Q1-Q3**	**df % Q2-Q3**
It is not ideal, but acceptable, if relatives or children of the patient translate.	f	35	17,8	25	12,8	27	21,1	-5,0	3,3	8,3
It is important not to enter into the conversation with preconceptions about victims and perpetrators.	t	167	84,8	172	87,8	112	87,5	3,0	2,7	-0,3
If an accompanying person is present, he/she should be included in the conversation.	f	12	6,1	5	2,6	6	4,7	-3,5	-1,4	2,1
If patients are not willing to talk about the situation, this should be accepted.	t	139	70,6	166	84,7	98	76,6	14,1	6,0	-8,1

3.5. Interim Conclusions

Data from the three surveys (before the training, Q1; after the training, Q2; six months after the training, Q3) clearly demonstrates the effectiveness of the VIPROM-trainings. Intended target groups were reached, especially doctors and nurses, and their needs met. Looking at the gender distribution of trainees, it is striking that significantly more women than men took part in all occupational groups among medical professionals. The most likely is that women are more interested in the topic of domestic violence and engage with it more willingly. For further training and awareness raising it will therefore be of great importance to clarify that DV is not a “women’s issue”, even if it is thoroughly gendered. Naturally, this is not a task for one project but a continuous effort by the whole violence protection system. Furthermore, the data indicate that among medical professionals, it was primarily older age groups who attended training sessions – this can be interpreted as an indicator that there is a need for training on domestic violence in the medical sector including for very experienced professionals. VIPROM addresses this gap. That the trainings answered needs is further confirmed by high ratings for the relevance of VIPROM content for work in hospitals. A comparable need can also be seen among students: domestic violence often did not play a significant role in their studies until they attended the VIPROM-training.

Both, medical students and medical professionals rate their knowledge and skills relating to domestic violence higher after the training (Q2), with medical students showing larger gains. This can be explained by the fact that medical professionals participating in VIPROM-trainings were already more knowledgeable pre-training (Q1) than students.

Knowledge gains through VIPROM-training were assessed using self-assessment questions completed by the trainees and multiple-choice questions with the latter enabling a more objective assessment of knowledge changes between surveys. Changes in terms of skills for dealing with domestic violence, on the other hand, were assessed exclusively through self-assessment which limits generalizability. This is partially offset by the fact that our main focus was on changes, i.e. comparisons between surveys not on defining the precise scope of participants’ knowledge. Simply put, it did not matter that much whether participants’ self-assessments were correct as long as they were consistent and therefore comparable over time.

Data from the third survey date (Q3), in which participants provided information about the actual applicability of the content in their daily work further added to our understanding. Overall gains in knowledge and skills for both groups are evident in the self-assessment questions relating to domestic violence as well as in the multiple-choice questions. The multiple-choice questions also showed that certain aspects of domestic violence seem to be easier to train in a sustainable manner than others. Data obtained from the questionnaire after six months (Q3) showed largely consistent positive and lasting training effects, with overall only minimal to little decreases. A few exceptions to this overall picture within the student group might be taken up in the design of further trainings.

The trainings were met with great satisfaction by both groups (Q2), and their applicability in further studies or in hospital work was also rated very highly. While some of the didactic approaches used in the trainings were applied in a similar way to students and medical professionals (e.g., lectures, inputs), interactive methods such as group discussions were used more frequently with medical professionals. Combined with the high level of satisfaction among respondents, this shows that VIPROM-trainers successfully tailored the trainings to their respective target groups.

Data also show that both the variety of interactive methods and the perceived quality of VIPROM-trainings positively influenced participants' satisfaction, knowledge gain, and the applicability of content, though effects differ across professional groups. For medical students and doctors, methodological diversity—particularly the use of role-playing and case studies—was associated with higher training satisfaction, greater perceived knowledge gain, and improved applicability in practice. For nurses, in contrast, interactive methods primarily enhanced perceptions of trainer expertise rather than overall training quality or content applicability.

Perceived training quality, knowledge gains and applicability of training content for medical professionals' work showed a clear relation. Follow-up analyses after six months confirmed the persistence of these effects, though results varied between professional groups. Overall, the findings highlight the importance of methodologically diverse, high-quality training for fostering sustainable knowledge acquisition and practical application, while suggesting that tailored approaches are required to address the differing needs and learning preferences diverse target groups.

4. Training Observations

Observations were included into the evaluation design in order to provide insights into the training settings from an 'observer's' position, i.e. someone not directly involved. Group dynamics, didactic and methodical approaches as well as the interactions among participants and between participants and trainers were defined as focus points.

As per the evaluation planning (see Deliverable 5.1) at least one training was observed in each of the six training locations (Annex 7.8 Guidelines and Template for Observation). Especially strong data is available for the Greek case, where seven different training settings (three for different groups of medical professionals and four for students) were observed, while in all other location one training (either for students or for medical professionals) was chosen. The decision not to observe all trainings, but select one in each location was taken in order to keep the workload manageable for all partners.

4.1. Trainings for Medical Professionals

Trainings for medical professionals were observed in Greece, Italy, Sweden and Austria. The training-groups varied considerably in size, composition and the training's time-frame.

4.1.1. Groups, Trainers and Setting

In Greece three trainings were observed, each targeting a specific stakeholder-group, although for organisational reasons some flexibility was necessary. As a result, one training-group consisted of twelve doctors with different specialisations, while the two other groups (14 and 13 participants) were comprised mainly of nurses and midwives respectively, but included a few participants with different backgrounds each. For Austria one training for a group of 14 doctors (again with different specializations and positions) was observed, providing a somewhat similar setting to the first Greek group. Contrast is provided by data from Italy and Sweden: In Italy one training with a large group of about 50 participants was observed, which

included different professions (doctors, nurses, obstetricians, psychologists), while in Sweden the observed training-group was comprised of six doctors and one nurse/midwife.

In terms of participants' gender all groups showed the typical bias of more women being interested in the topic (and ready to sacrifice parts of their weekend). In Sweden all participants were female and no training in any location had more than a quarter of male participants. The highest share of men was reached among doctors.

Not only had size of training groups varied between locations, but also the time-frame. The Austrian training was the shortest with four hours of intensive work focused mainly on the trainer's input with questions by participants and a few interactive elements, complemented by about an hour of informal discussion and exchange afterwards. In Sweden trainings were also held on one day, lasting for eight hours (including lunch break) and a self-study part of four hours for Module 8. Longer trainings were held in Greece, taking place on two consecutive days with eight hours on the first and three to four hours on the second day (including breaks). Two of the trainings also included a four-hour self-study part. The longest trainings were held in Italy and were comprised of 16 hours of face-to-face sessions over the course of two weekends. Besides, Module 8 was suggested for self-study.

All trainers had ample experience in the medical field with their different professional backgrounds often mirroring the main intended audience. All were also very experienced in DV-related issues and most were already very well versed in teaching about these subjects before joining the VIPROM-project. While in Austria and Greece each training was conducted by one trainer, in the Swedish and Italian cases teams of two or more trainers worked together. Notably women were not only overrepresented among participants, but also among trainers as all of them were female.

4.1.2. Setting the Stage: Creating and Maintaining a Safe Space

Observers noted unanimously that trainers succeeded in creating an open and welcoming atmosphere, which encouraged participants to feel safe and allowed them to pose questions and share experiences freely. This approach allowed participants to also talk about encounters with (potential) victims of DV, in which they felt unsure about the right course of action, encountered institutional barriers and/or in hindsight doubted their own decisions. All observations also highlighted the wealth of questions asked by participants as well the respectful atmosphere as markers of the successful creation of a safe space. The creation of a warm atmosphere, which – even given the grave nature of the topics covered – allowed for occasional laughter, was mentioned several times as a key feature.

The observations showed that the very beginning of the training, i.e. the way trainers introduced themselves and – maybe even more importantly – how they handled participants' introductions were vital in establishing this positive atmosphere. Giving participants the possibility to establish themselves as professionals with ample expertise in various fields and acknowledging this expertise throughout the training proved vital in establishing a collaborative atmosphere.

These communalities notwithstanding observations also showed that quite different approaches could work for different groups of participants in different settings. In a few cases participants and trainers were acquainted and collaborated in their daily work, mitigating the need for extensive introductory rounds. In other cases trainers' presented not only their professional credentials, but also provided some personal insights, e.g. on their motivation for

working on DV-issues in the medical sector. Most trainers did not use a specific method for introduction rounds, but facilitated participants' involvement by asking for prior knowledge and/or expectations. The Italian case, i.e. the biggest group, was the exception as trainers kicked-off the session with the game "what do you always have in your backpack?" In one training in Greece name tags displaying participants' first names were used to foster a sense of approachability and collaboration.

Only in the Swedish case trainers explicitly mentioned the possibility of personal experiences with violence among participants and encouraged them to reach out for support if needed. Even though there were no reports of any distress among participants in the other cases, we believe this to be a *good practice* that should be incorporated in trainings complementing input on self-care.

While all training settings were marked by a very high engagement of participants a closer look at interactions reveals some differences as well: In the Austrian case questions by participants were mostly directed at the trainer, and only to a lesser extent to their peers. This might be explained by the trainer's status as a specialised DV-expert working at a big Austrian hospital, i.e. as one of *the* experts on DV in the medical field, by the trainings' focus on expert input rather than collective reflection but also by the physical setting of the room, which resembled a traditional classroom. Nevertheless here as well in some other settings trainers' strategies of posing open questions and encouraging everyone to respond proved successful in ensuring participation. Trainers in various locations also showed great skills in overcoming subtle barriers, e.g. with regard to the reflection of (participants' own) stereotypes or in motivating the sharing of experiences among participants by starting from their own practice. The importance of breaks in a comfortable setting, which fostered informal conversations, was also mentioned by various observers as one element of training success.

A somewhat contrasting example to a training style mainly focused on expert input can be found in one of the examples from Greece, where the observation report described the trainers' style as "balancing the roles of moderator and counsellor", which led to the training being marked by a high-degree of peer-learning. This was further strengthened by the trainers' decision to start the closing session by sharing her own impressions, feelings, and thoughts about the training and encouraging participants to do the same.

All observers agreed that hierarchies, e.g. due to professional background, gender (note that the majority of participants were female), age or other social markers, were noticeably absent. Interestingly in cases where slight differences could be observed, they do not provide a clear-cut picture. While in one of the Greek cases older participants tended to lead with questions and experiences, in the Swedish case, especially in the beginning, younger participants proved to be more active. Some differences also pertained to issues that came up in some groups but not in others. E.g. in one training the need for changes in doctors' mind-sets, i.e. a move away from a 'rescuer' to someone who supports DV-victims in their own decision-making, came to the front, while other trainings mainly focussed medical professionals' agency. Yet, out of the (limited) data no clear picture emerges, which would allow us to connect these differences systematically to different groups of stakeholders.

A measure of training success can be seen in the fact that participants in various locations not only expressed their willingness to participate in further trainings and recommended to broaden the scope of target groups, but also stayed on after the official end of the training to discuss further experiences and/or to strategise about how their colleagues could be reached as well or how to incorporate DV into mandatory trainings.

4.1.3. Didactics and Methods

In line with the VIPROM-training concept all trainers used a mix of different methods. There were some notable differences, which reflect individual teaching styles as well as different group settings. Among the didactic methods and training materials mentioned by observers were lectures (slides) and conversation, discussions, videos, role plays and case studies. One observer from Greece specifically mentioned the use of cartoons, which resonated very well with participants and sparked discussions among the group, acting as a starting point for the sharing of perspectives and insights. In Italy the observed training included the invitation of a representative from an anti-violence centre, who provided further information on the support the centre offers to victims of DV. As already stated, open questions were used by all trainers in order to engage participants and to make sure the training was adequately addressing participants' needs. One observer from Greece noted that the trainer used questions systematically to check participants' understanding of the issues covered so that any misunderstandings could be immediately addressed.

Most importantly, all observers mentioned the strong focus of the VIPROM-trainings on real-world experiences, using trainers' individual experiences, case studies and well-designed scenarios. This made it possible for participants to connect the training content directly to their own experiences, but also allowed for an experiential scenario-/problem-based style of teaching and learning that proved very effective. These types of exercises prompted participants to apply existing knowledge, fostered critical thinking and deepened their understanding. In practice this methodical approach could take the form of short exercises – e.g. on how to avoid common pitfalls in the documentation of a case of DV – or elaborate scenarios covering the development of a case over longer periods of time.

Role play (often as part of scenarios or case studies) also proved to be very important as e.g. communication exercises allowed participants to train not only a wide range of knowledge (e.g. detecting risk factors or understanding the legal situation), but also empathy with victims and practical skills in listening and communication.

This focus on experiences, cases and scenarios notwithstanding also more common forms of teaching and learning proved to be important for participants. The observer in the Italian case mentioned i.a. a worksheet featuring possible questions for communicating with victims as an important resource for participants. At many locations also information on the legal situation was covered as a sound understanding of the legal situation provides an important basis for developing the agency of medical professionals in cases of DV.

In summary, the observations clearly showed the importance of offering a diversity of didactic styles, allowing trainers to customize the training in a way they felt comfortable teaching and catering to the different needs and preferences of participants. Including elements that focussed on values and skills like empathy and communication (besides the cognitive aspects) proved especially successful in engaging participants.

4.1.4. Discussing Challenges and Strengthening Agency

Some observers noted challenges with regards to stereotypes brought forward by participants, e.g. on gender in relation to stereotypical expectations of men and women and/or heterosexual and same-sex couples or regarding gendered stereotypes about ethnic minorities and

immigrants. The trainings provided an important space for participants to voice concerns in relation to specific groups of patients' – e.g. Roma in Greece – among whom they noticed potentially harmful practices, which they found difficult to address. In this regard, it is important to highlight once again that the safe space provided in the VIPROM-trainings allowed participants to share difficult experiences, including situations where they felt their own reaction had fallen short of their own ideals. In other settings participants especially highlighted the content of Module 8 on stereotypes as providing useful tools for reflecting on their own biases as well as on institutional difficulties in connection with groups of vulnerable patients, e.g. women with addiction issues.

Yet, most debates related to challenges faced by medical professionals in relation to institutional barriers. These included the stressful working environment in emergency rooms, which makes it difficult to truly engage with potential victims, who in some cases might show behaviour that is difficult to manage for medical professionals. Another important aspect debated in some contexts was the lack of procedures and institutionalised practices with regards to documentation and legal proceedings. In Austria difficulties with the practices of ambulance services that document cases of DV as a form of 'fight' rather than as a case of violence were noted. The amount of questions raised by participants in connection with issues of consent, the (photographic) documentation of injuries and the responsibility for filing legal complaints clearly showed the need for targeted trainings to strengthen medical professionals' agency in these regards. Institutional shortcomings were also mentioned by participants in relation to translation as professional interpreters are often not readily available in clinical settings. This is an especially grave concern as it can (understandably) lead to medical professionals relying on patients' relatives for translation, which is of a course a potential danger in the context of DV. The issue of technological tools like translation apps sparked debate as their use was banned by some institutions yet in the absence of professional interpreters, they might sometimes provide the only solution available.

While these critical statements highlighted institutional barriers, one of the strengths of the trainings, which was noted across all contexts, was the focus on developing solutions rather than focussing on the problems as such. Especially the practical input on how to start a conversation on DV with a (suspected) victim and the identification of 'red flags' were deemed very helpful by participants. Participants also discussed frustrating experiences when victim's denied to accept the help offered. Learning about possibilities to gently offer further assistance while respecting the patients' autonomy can lighten feelings of guilt or self-doubt on the side of professionals, who 'want to make a difference', thereby also helping to avoid burnout.

4.2. Trainings for Students

Trainings for students were observed in two different locations in Germany and in two cities in Greece. Data regarding trainings for students is less varied than the data described above for medical professionals in terms of location, group size and (of course) differences in age and professional backgrounds of participants. The inclusion of one German group consisting not of medical students but of nurses-in-training offers interesting options for comparison.

4.2.1. Groups, Trainers and Settings

The Greek team observed four trainings for medical students held in Athens and Thessaloniki. All trainings had the same basic structure: They were held on weekends with an eight-hour

session on Saturday and another four hours of training on Sunday (including breaks). Additional material for self-study was provided in all cases with an estimated workload of four hours.

The number of participants in the trainings ranged from nine to 13, with composition by gender mirroring the settings for medical professionals with women outnumbering men by far – the highest share of men was on third, while one group consisted entirely of women. Concerning age most participants were in their early 20s with one group in Athens showing the broadest span with participants aged 19 to 28. This group was comprised of students of different Medical Universities (including participants travelling from Cyprus and Crete to the Greek capital in order to be able to participate in the training). Most of the participants in Athens had only limited prior knowledge on DV and had not received prior education in the course of their medical studies. In Thessaloniki the observer especially noted that many participants were motivated by experiences in their clinical practice (e.g. during internships), which confronted them with cases of DV. Participants especially highlighted a lack of training concerning documentation.

The first observation from Germany was of a group of 17 medical students from Münster University, with two men among the participants. With regards to prior knowledge the group appeared to be more mixed with levels of knowledge ranging from “little” to “good” as described by the observer. As in Greece the training took place over the weekend with a duration of six hours each day (including breaks) and a self-study part.[1] The second training in Germany differed in terms of target group as well as timing and set-up, as trainees consisted of a group of eight nursing school students (one man, seven women), who received the VIPROM-training in one 8-hour face-to-face session with breaks following students’ needs. In this case, the age of the students varied between 20 and 28 years. Observers rated the prior knowledge of this group as ranging from limited to good and especially noted that the students already had a lot of knowledge about red flags in relationships, stalking and hierarchies with some hinting at prior experiences in their social environment.

All trainers had ample experience in trainings on domestic violence in the medical sector. While the trainings in Thessaloniki and the one for nurses-in-training in Germany were offered by one trainer, the trainings in Athens were delivered in tandem and German medical students in Münster received instructions from three trainers.

4.2.2. Setting the Stage: Creating and Maintaining a Safe Space

The creation of a safe space for students to debate and learn was maybe even more important than in the trainings for professionals. One observer in Greece noted that trainers deliberately seated participants close to each other to foster a climate of comfort and collaboration. In another case work in smaller groups was used to foster a collaborative atmosphere. Trainers used various methods to establish mutual trust from the very beginning, starting e.g. with easily accessible introduction rounds (for example sharing three items they usually had in their bags and asking students to do the same or sharing one item and explaining its connection to one aspect of one’s personality) and/or by introducing themselves not only as professionals

[1] In line with organisational prerequisites the training covered 28 semester hours (à 45 minutes) in total (pure working hours excluding breaks). For reasons of comparability across locations we focus on the duration of the training in full hours. We also include the breaks as all observations show that well designed breaks are an important part of a productive learning experience.

but also mentioning their motivation for working in the field of DV and sharing information on their previous collaborations and personal bond. These were some of the ways in which trainers established themselves as role models on a level basis with all participants. By taking all these careful steps and by explicitly valuing all contributions, trainers were able to guarantee equal and open participation among the whole group. The effects of this atmosphere were captured by one observer from Greece describing that on the second day students, who had not known each other beforehand, “were sitting together and had exchanged contact information”.

The group in Münster explicitly used the Chatham House rules, i.e. it was guaranteed that any information from the training would only be disclosed in an anonymous fashion. In order to strengthen the feeling of being in a protected space, people outside the group who entered the room were immediately asked to leave and their questions were being addressed outside.

A slightly different approach to creating a safe space and setting clear rules was taken by the trainer for nursing school students in Germany, who explicitly asked students’ consent to address them in an informal manner (first names) and even more importantly asked for consent on addressing students actively, i.e. even if they hadn’t raised their hand. This approach was taken to ensure that all participants would actively take part in discussions. By asking students’ consent beforehand and using engaging questions all through the training the trainer managed to establish a low-hierarchy atmosphere, even as she kept a clear profile as expert and teacher.

In all cases participants felt safe to bring their own experiences (e.g. from internships) to the group, which added a variety of viewpoints and practical examples that participants could directly relate to. Especially in the first training in Germany (Münster University) where participants’ prior knowledge varied widely, observers noted that this approach encouraged peer-learning. Greek observers also mentioned that participants often posed direct questions to their peers, asking for opinions, strategies and suggestions for actions in relation to (difficult) experiences. The safe atmosphere also allowed participants to reflect deeply and personally on issues of DV in their own lives. The observer also reported that for this group the trainers also conducted a self-care assessment in the group-setting, which was successful in creating a joyful but also intimate atmosphere. Reflective questions, which also included emotional responses to the topic, helped to keep this safe space for reflection open through the whole training. In the second training in Germany observers noted that among the nursing school students debates were most lively when experiences from the clinic were being discussed. In this case the trainer picked up a recent DV case two students of the group had witnessed and then worked on a possible solution with the group.

Importantly, the open and safe atmosphere allowed trainers to deal with potentially challenging situations – e.g. in relation to biases or stereotypes or to debates on somewhat contested issues – as opportunities for reflection and learning rather than as disturbances. One observer noted how one of the trainers skilfully broke the ice on a reflection of stereotypes by starting the discussion with a personal reflection, thereby leading and encouraging participants by example.

Much consideration also went into how to activate and assess participants’ prior knowledge as well as their expectations for the training. Again trainers used different methods, ranging from free association on key psychological terms in the field of DV, to making a full round with every participant voicing their reasons for attending the training and their expectations for the training. In the German training for student nurses the trainer started the session with a 10-minute research task, presenting students with a fictional case of a woman with three kids

(with the oldest boy being 12), who claimed that she couldn't go home to her violent partner. The students had to search for a space in a women's shelter and encountered barriers in this exercise (e.g. all nearby shelters were full, some didn't take boys aged 12 etc.), which immediately sensitised the students for the topics.

Trainers also used slightly different approaches to conclude the trainings on a reflective note and collect students' feedback. In one German group students explicitly mentioned in their feedback that they experienced the training as a safe space. The positive resonance also showed in the trainings in Greece, where participants especially highlighted the experiential learning approach, the interactive participation and peer-learning as important parts of their positive training experience. One comment by a participant voiced how the VIPROM-training not only expanded their knowledge on DV but helped them develop skills and strengthen their agency: "Leaving this training, I don't feel completely ready to communicate with a suspected victim of abuse, but I feel much less uncomfortable doing so." Greek participants also suggested spreading the trainings nationwide and/or repeating the training with a focus on documentation of DV cases.

4.2.3. Didactics and Methods

All trainers used a broad range of methods and materials in their training sessions with a focus on keeping students' attention and fostering interaction. For example targeted questions were used to engage participants and create a feedback loop throughout the training, which e.g. allowed trainers at Münster University to flexibly tailor contents to participants' needs. Another observer described a comparable approach by Greek trainers, who used specific questions – partly assessing knowledge, partly inviting reflection – to start thematic sessions with open discussions thereby activating and assessing participants' knowledge. A slightly different approach used analyses and discussions of concepts like "understanding" or "empathy" as a starting point. "Flexibility" seems to be the one term all observers used at one point or another to describe trainers' handling of the sessions and their ability to competently react to participants' questions and specific interests on the spot. Flexibility was also needed with regards to time management as e.g. role plays and their subsequent reflection tended to take up more time than originally allocated.

In all cases presentation and lectures were part of the training, in many cases kept in a conversational and interactive style that fostered participation. The VIPROM-training platform was used a resource and to invite further self-study. In one case in Greece it was also integrated directly into the training, e.g. using quizzes available on the platform. But the focus in all settings was on interaction and engagement. An observer in Germany listed the interactive methods used in the training as follows: "role-plays, online surveys via Mentimeter, group work on flip charts, handouts, video clips, reflective listening, relaxation exercises, and group tasks". Students in this case commented especially favourable on the role plays. These were also used by trainers in Greece in order to develop students' empathy and communication skills and give them a better understanding of the psychological state of DV victims. This approach worked very well in all locations and represents one central pillar of the VIPROM-trainings. Students in Athens for example used the role plays for further questions and critical examination of the scope of action for medical professionals. They started from the situation – e.g. communication with a patient – as presented in the role play, but went on to further questions on inter-organisational cooperation, specific issues in connection with children as victims etc. Trainers took this opportunity to emphasize that professionals need to

focus on what is achievable, practice self-care, and accept help. They reminded participants that “changes are made from within.”

One example of trainers’ flexibility in assessing the group’s needs was provided by an observer from the German training for student nurses. As students (despite having agreed beforehand) were reluctant to step-up and perform the solution to a scenario in front of their peers, the trainer switched to letting the students work in small groups for some more time, before accompanying one scenario using a “thinking aloud”-approach. In order to ensure relevancy of the scenarios the trainer had included aspects and phrases from students’ experiences, which had been discussed before.

A somewhat similar version of a scenario-based group activity was described for the training in Thessaloniki, where students were assigned hypothetical DV scenarios, which they then analysed while sharing their thoughts and concerns. Case studies using real-life examples were used in n other locations. One observer at Athens University specifically described how (cartoon) videos and music was used by trainers in order to stimulate a debate on gender stereotypes and other kinds of biases. In all locations reflection was a key feature of the trainings. Besides the designated reflective exercises one observer pointed especially to the importance of well-designed breaks that allowed participants to process information.

Feedback was not necessarily one-directional but included – as one observer from Greece noted – trainers’ favourable comments on participants’ contributions. This approach was used to strengthen the application of learnings and to help build a network of learners post-training.

4.2.4. Main Topics of Discussion, Challenges and Strengthening Agency

Concerning how to deal with challenges arising in the trainings themselves we find a common theme in all trainings. E.g. the observation protocol from the training at Münster University states: “Due to the general atmosphere performed by the trainers as role models potentially challenging situations were no seen as challenge but as an opportunity”. In a similar vein an observer from Greece noted, how trainers handled sensitive topic, including a heated (but still respectful) debate between participants on the balance between respecting cultural beliefs and opposing violence. Trainers in this case redirected the debate towards self-awareness, emphasising how personal beliefs might influence professional decision-making and communication, thereby turning the situation into a learning opportunity.

Challenges connected to training content rather pertained to preparation than to the actual trainings. Trainers had to choose which topics to include in which depth in the training given the limited time.[2] In their – highly positive – feedback on the training in Münster participants voiced that they would have liked to learn more about inter-organisational cooperation (e.g. cooperation with women’s shelters or the police), which had not been part of this training due to the decision to include a focus on self-care. Balancing the amount of topics and material with the necessary depth of engagement and skill-development within a given timeframe is of course a challenge for any kind of training, especially as participants’ expectations and needs may vary widely between groups. As the VIPROM-platform provides a huge amount of material this underlines the necessity for trainers to choose and define focus points for each training in accordance with participants’ needs.

[2] This issue was discussed in more detail in the trainer focus groups, see section 5.3.

Observers also noted which issues sparked most interest among students and/or were most profoundly debated. There was some variety between locations, with students in Münster being most interested in the communication training and the exercise on documentation, as well as the role of children in cases of domestic violence while their Greek counterparts debated i.a. about different (mostly less well-known) forms of DV and their connection to other harmful behaviour as well as the role of stereotypes in recognising DV. The nursing school students were most interested in discussing examples from their clinical practice, probably reflecting the more practice- and patient-oriented focus of their studies when compared to medical students.

Most notably the issue of documentation of DV cases sparked huge interest among Greek students just as it had among medical professionals. Students identified this issue as a main institutional barrier in the Greek medical system as specific protocols and proper training for documenting and photographing evidence of DV and sexual violence as well as for the further handling of evidence were lacking. They therefore encouraged focussed trainings on documentation to be held in the future. Further challenges within the medical system identified by the students were stereotypes, e.g. against men as victims of DV, but also a lack of action plans for professionals and of information material for patients including information on social and translation services. Debates also arose around questions of medical professionals' duties in terms of reporting cases of DV to the authorities.

4.3. Interim Conclusions

As a first partial conclusion the observations clearly showed that the VIPROM-trainings were spot-on in addressing concerns and needs by medical professionals and students when dealing with DV. Especially the mixture of different didactic approaches, the wealth of material serving different styles of learning, and the safe space provided for sharing own experiences and reflecting on possible courses of action were welcomed by participants in all training locations. The hands-on approach of experiential learning (case studies, scenarios, role plays) shows high potential for providing sustainable learning effects among participants. Slight differences between medical professionals and students are visible insofar as professionals with more experience in clinical settings tended to profit immensely from sharing and discussing these experiences with their peers, while for students e.g. well-prepared role plays or scenarios functioned in a comparable manner.

A second finding relates to the general VIPROM-approach with its focus on agency, opportunities and possibilities for change. While there was room to discuss the varied, partly context-specific challenges and institutional shortcomings in the medical sector, trainers steered debates towards the question 'what can be done?', i.e. towards agency and positive practices. Despite the severity of the topics discussed this made the trainings a positive experience for participants, who learned about new possibilities for 'making a difference'.

Many observers also stressed trainers' ability to react directly to participants' needs and to adapt their trainings accordingly. In line with the focus on agency, specific needs (i.e. in the field of documentation) may even warrant specifically focussed trainings. These could build on the VIPROM-material, but might have to be adapted to fit local needs (e.g. integration in hospital routines).

Last but not least, the observations hinted at the need for trainers to choose not only didactic tools but also focus topics for each training from the VIPROM-material, as due to time

constraints it is impossible to cover all aspects in a single training. Of course training duration matters greatly in this respect, but – as will become more obvious in the next section on trainers' perspectives – simply offering longer trainings might be difficult especially when the target group are medical professionals.

5. Trainers' Perspectives

Trainers' perspectives on the VIPROM-trainings were collected at three points during the VIPROM-training cycle. First, written feedback on the TtT-events – both the international event in Münster and the national TtTs – was collected directly after the trainings (Annex 7.9. Trainer feedback-form). Second, observers at the different pilot training sites were asked to have an informal chat with the trainers directly afterwards in order to collect and report first insights and immediate impressions. Last, focus groups were held with trainers in order to compare insights from different countries and offer a space for sharing and reflecting of training experiences. Due to scheduling conflicts in one case an individual interview had to be held.

5.1. Feedback after Train the Trainer-Events

In total, 29 trainers from all partner countries filled in the feedback form for trainers after taking part in Train-the-Trainer-events (see Deliverable 4.1 Report on Train-the-Trainers courses). 13 of these feedbacks were collected after the international workshop in Münster in September 2024; the others were collected after national TtT-events. It is important to mention that the event in Münster used the possibility to work with professional simulations (i.e. a simulated clinic with actors portraying patients/potential DV victims), which were highly appreciated by participants, who had the chance to take part (n=12). As these resources were not available at other locations feedback on the simulations only relates to this subgroup.

5.1.1. Trainers' Backgrounds

Of the 29 trainers who filled in the feedback forms, 26 were female and three male, mirroring the unequal gender balance we find throughout the project as well as in the field of DV more generally. In terms of age however there was great diversity, with the youngest participant being 27 and the oldest 69 years, on average trainers' age was 50 years. Previous experiences with DV in the medical sector and with training medical professionals in related issues were equally varied: Experience with DV ranged from none to 30 years (average: 12 years) and trainings experience from none to 20 years (average: 5 years). One trainer also remarked that while she started training medical professionals only two years ago, she had much longer experience training police officers as well as professionals from shelters and counselling centres.

Concerning their professional background twelve trainers were medical doctors (with varying specialisations), three nurses and four psychologists. Nine participants marked "other" in terms of professional background, revealing a varied field of professions from research and teaching in medicine, law, and the natural as well as the social sciences, to didactic specialists and advisors on equal opportunities.

5.1.2. Feedback on the TtT

Participants were asked to rate training quality first in general (Tab. 16) then along a number of dimensions on a scale from 1 (lacking/very bad) to 10 (very high/very good). The following table shows the average and standard deviation (SD) as well as the median for each question:

Table 16. Trainers' feedback: General impression (scale 1-10; n=29)

Dimension	M	SD	Median
Overall quality of the training content	8,93	1,11	9,0
Structure of the training	8,52	1,43	9,0
Presentation and didactic methods	8,86	1,46	9,0
Relevance for DV-related work in hospitals[3]	8,86	1,53	9,5
Relevance of training for your own DV-related trainings	8,93	1,31	9,0

These results clearly show that the quality and relevance of the TtT was regarded as very high by trainers. Even more importantly trainers also ranked the relevance of the training very highly both for DV-related work at the hospital and for their own preparation of future trainings.

A second block of items asked participant to agree or disagree (again on a scale from 1 to 10) with statements about content and the perceived impact of the trainings. The table (Tab. 17) again sums up results.

[3] For this question n=28 as one person did not answer.

Table 17. Trainers' feedback: Specific statements (scale 1-10; n=29)

Statement	M	SD	Median
The training content was interesting for me.	9,28	0,87	9,0
I can use the contents in my daily work at the hospital.[4]	8,17	2,07	9,0
I feel well prepared for my own VIPROM-trainings.	8,00	1,93	8,0
I learned something new during the training.	8,38	1,85	9,0
The training platforms (modules) are helpful for the preparation of my own trainings.	9,34	0,96	10,0
If VIRPOM trainings are delivered broadly it will make a difference for the way hospitals support victims of DV.	9,41	0,89	10,0

While we see consistent high levels of agreement by trainers with these statements about the VIPROM-TtT and the prospective impact of the trainings, we also see a bit more variance than in their general remarks. Higher standard deviations are mainly an effect of individual trainer's less favourable ratings of certain aspects (statements 2, 3 and 4).

Interestingly participants' confidence in their own ability to conduct a VIPROM-training (statement 3) was comparatively lower than their rating of the training they just received. Partly, this might be explained by the fact that the feedback was collected directly after the trainings, without giving participants time to reflect on the wealth of information they had received, which might explain a feeling of being overwhelmed. Partly it might reflect a certain anxiety about holding their own trainings. This could also be seen in some of the comments trainers left in the open fields, with some believing that the TtT (in this case set to 1,5 days) had been too short, some commenting that the wealth of material on the training platform was overwhelming, which could be an obstacle in the recruitment of further trainers, and some calling for more guidelines and templates (e.g. for preparing slides) to make training preparation less time consuming.

These somewhat critical remarks, which pointed to potential challenges identified by trainers notwithstanding, the training platform was nearly unequivocally rated very highly as a resource for the preparation of trainings. This not only shows in the numbers given above, but also in the open comments. The last two fields of the survey were open fields, one asking trainers what they especially liked about the TtT, the other asking for possible improvements. Most trainers took the opportunity to leave some remarks, partly relating directly to the training experience at hand, partly voicing broader issues. In the following we sum up some of the main points that were voiced repeatedly and have not yet been covered. As the TtTs have been held in different locations and by different people we excluded comments that were voiced only once and presumably relate to a very specific training setting and/or clearly reflect individual viewpoints and opinions.

[4] For this question n=24.

In relation to the training experience the creation of a “safe space” and the “great atmosphere” was mentioned repeatedly. For those that could take part the simulation, it proved an especially valuable experience, with very few negative remarks. The same pattern emerges with the interactive parts of the TtT in all locations. Several trainers also mentioned the detailed guidance on how to design their own trainings as well as the handbook as especially helpful, while (as mentioned above) some wished for even more tools (e.g. a full set of ready-to-use-slides). The feedback very clearly shows that the VIPROM-approach is walking a fine line: On the one hand it needs to offer trainers a wide variety of materials to choose from (in terms of content as well as in terms of didactic methods) as a prerequisite for an individualisation of trainings in line with trainers’ and learners’ needs, on the other hand there is a danger of overburdening (new) trainers, who have to familiarize themselves with large amounts of material in order to be able to make well-informed choices. The feedback shows that trainers were aware of these potential challenges, while at the same time valuing the breath and diversity of the material. As we will show in the following sections on trainers’ feedback *after* they held their own trainings the value of flexibility became evident in practice. In terms of content, trainers’ ranked communication, reflection on stereotypes and self-care[5] as especially beneficial.

Regarding critical remarks a big share of those concerned practical and organisational issues (from the number of breaks, to food or the setting of the room). Besides the comments already mentioned above, with many pointing to a perceived lack of time, individual participants found that the TtT would benefit from a clearer focus on trainers, i.e. being more clearly structured around pedagogical tools, while another remarked that not all VIPROM-content would fit the “reality of practice” in the medical sector.

Last but not least, trainers were asked for their assessment whether VIPROM-trainings if delivered broadly would make a difference to practices of dealing with victims of DV in hospitals (see Table 17). Trainers unequivocal rated this prospective positive impact very highly.

5.2. Impressions after Trainings

Immediately after the trainings concluded, observers at various training sites (see section 4) held short informal chats with trainers in order to gather first impressions and spontaneous insights. Necessarily this data is less systematic than that collected for other parts of the evaluation, but it still offers glimpses into common perceptions of strengths and challenges. We will first describe the main points of the conversations held with trainers after trainings for medical professionals (locations: three trainings in Greece for different stakeholders, trainings in Italy, Sweden and Austria) and then turn to the trainings held for students, which encompass two locations in Germany (one for medical students, one for nurses-in-training) and three settings in Greece.

[5] This is one example of the diversity of viewpoints: While the issue of self-care was mentioned in a positive manner repeatedly, it was also called “unnecessary much” in one individual comment.

5.2.1. Trainings for Medical Professionals

All trainers without exception commented favourably on the trainings as they believed that participants reached the defined learning goals. The wealth of material and the diversity of methods were rated as important tools in this respect. One trainer noted that she had not been sure beforehand, whether the chosen materials would fit the needs of the group, but it turned out to open up valuable possibilities for exchange and discussion. Comparing different settings the importance of flexibility in the application of different methods was obvious. In one case the role play exercise went much faster than anticipated as not all participants took part, while in another the trainer voiced here surprised about how well participants' liked this exercise.

In line with observers' reports, trainers commented on the importance of the exchange of experiences among participants as this engaged participants and simultaneously ensured the practical relevance of training contents.

All trainers also stressed the high level of engagement from participants, which made it a rewarding experience. One trainer from Austria noted that not all questions posed by participants were easy to answer as they touched upon very complicated situations, experiences and local contexts, where clear-cut solutions are hard to find. She remarked that an open and honest approach including on the limits of one's own knowledge was important to handle such situations well. One of her goals was to show participants that in most situations there is more than one 'right' way to support victims of DV. In a somewhat similar manner a trainer from Greece commented on the multitude of questions pertaining to the legal and institutional framework for managing cases of DV. She also noted that participants expressed a newfound confidence in their ability to contribute to the development of protocols for reporting GBV incidents, underlining the transformative impact of the training. This potential for transformative effects of the training also became visible in two Greek groups consisting mainly of midwives and nurses, as participants actively sought ways to maintain communication and foster collaboration beyond the training sessions. They exchanged contact information, with the idea to build a professional network in the field of DV, which should i.a. promote continuous learning through shared experiences.

Trainers were also asked about challenges they encountered during their trainings for medical professionals. Answers can be loosely fitted in two groups: a) challenges in preparation (including recruitment of trainees) and b) challenges during the trainings, with the first being mentioned more regularly.

Regarding the preparation of the trainings (see Deliverable 4.2 Report on the Piloting of the Training Curricula, which includes details on the recruitment process) some trainers reported a very high workload due to the extensive material, which was not covered by the allotted time, thereby forcing them to prepare the training in their free time.[6] Several trainers reported that the prime challenge was not the training itself, but the recruitment of participants due to the tight schedule of medical professionals. Unsurprisingly therefore the time frame of the trainings was an issue for trainers and participants alike. At this point we notice somewhat of a distinction between medical doctors and other medical professionals, with trainers teaching doctors mulling over the pros and cons of offering shorter training sessions – which would allow more doctors to participate, but would need to cover different topics in subsequent sessions, thereby risking that not all participants received the whole training. One trainer

[6] The VIPROM-trainers had different background and occupational situations; therefore compensation schemes and allocated hours are not comparable across the different training locations.

mentioned that doing a two-day-session on her own was quite exhausting, so – although results were good – she'd prefer to shorten training duration to one day in the future. Conversely, in two cases in Greece – both featuring slightly mixed training groups mainly consisting of nurses and midwives – participants voiced their interest in longer training sessions as well as repeating the training to gather even more in-depth knowledge and to further work on their skills.

One Greek trainer commented favourably on the professionally mixed group of midwives, nurses and health visitors. In her view diversity facilitated knowledge sharing and prompted reflection on possible improvements of individual practices. This indicates that even though needs of various professional groups differ, mixed groups can also provide benefits that might outweigh the challenges. Nevertheless some of our results indicate that medical doctors as a group face specific needs as well as limits that might pose challenges to broadly mixed groups. Still, the experience of a Swedish training showed that if participants are familiar with each other and work together on a daily basis these different backgrounds might not pose any difficulty. These contrasting experiences have been taken up in more depth in the focus groups (see 5.3).

One trainer remarked that it was challenging to remind participants over and over again to focus on possibilities for agency rather than on difficulties and obstacles. Also, dealing with stereotypes voiced by participants proved difficult and was made easier through feedback from the observer, who was trained in DV-issues as well. This fits with other trainers' responses who remarked on the importance of teaching as a team, which made it easier to overcome participants' initial reservations and allowed for mutual support.

5.2.2. Trainings for Students

Trainers for students echo the positive feedback of trainers for medical professionals. Several trainers commented favourably on reaching the training goals for their respective group and especially on the high level of engagement by the students. One German trainer explained that in her long-standing experience groups of that age and (small) size are often hard to engage, but that the VIPROM-training provided a different experience. One trainer from Greece reported that the training had helped participants to become more aware and to accept their role in addressing DV cases. This shows that VIPROM-trainings can be instrumental in establishing the relevance of the medical sector as the primary point of contact for many DV-victims.

A trainer team from Greece also drew a connection between the didactic methods used, participants' engagement and their own positive experience. They reported that they felt energised rather than fatigued after the two-day-training, crediting the group of participants for "pushing" them to delve deeper into the topics. Even during breaks, discussions about DV continued, underscoring participants' commitment and curiosity. Trainers analysed this as an effect of the high level of interactivity throughout the sessions and the dynamic atmosphere. They drew a direct line to learning outcomes, as the group demonstrated a deep psychological understanding and thoughtful analysis of the subject matter.

Another measure of success was provided by participants' eagerness to further engage with the topic, demonstrated in their interest to see the training repeated for all healthcare professionals as well as the fact that they exchanged contact information among themselves

as well as with trainers to maintain communication and potential collaboration. The focus on strengthening agency and building sustainable engagement came to fruit in these cases.

Turning to didactic methods more specifically, trainers highlighted the positive effects of role plays as they helped to involve participants. Also the use of experiential learning, e.g. using case studies and scenarios was mentioned. As one trainer remarked, “Emphasising experiential learning provided participants with transferable skills such as creativity, innovation, team collaboration, problem-solving, and critical thinking, making the application to real-world settings more feasible.”

When asked about challenges in connection with the training, the trainers raised different points. Trainers from Germany remarked that there were moments during the training, when participants held differing opinions, which resulted in interesting discussions, but which were always handled in the spirit of respectful dialogue. In a somewhat similar vein trainers from Greece remarked, that managing negative emotions, which arose through a debate on cultural respect, religion, and gender-based violence was among the most challenging situation throughout the training. They suggested expanding the teaching of Module 8 on stereotypes, which in this training had been content for self-study. To fully address these complex issues, they suggested rendering Module 8 a compulsory part of further VIPROM-trainings.

Another challenge in this setting involved addressing participants’ feelings of helplessness and frustration when victims refused help or when services and resources were limited. Trainers also observed that participants appeared most uncertain and uncomfortable during the risk assessment section, attributing this to its unfamiliarity, limited knowledge on this specific subject, and the complexities of interagency collaboration.

Trainers from Greece also made suggestions for a further expansion of training content. They had selected the material based on the needs assessment conducted during the VIPROM-project (WP2; Deliverable 2.1 Stakeholder Needs Assessment). Yet, feedback from participants suggested that due to variations in medical university curricula differences between the needs of different training groups might have been underestimated. In this instance, participants in the training e.g. reported significant gaps in their knowledge on child abuse and DV. Many felt unprepared to address issues involving balancing a child’s right to safety with a victim’s right to confidentiality, especially in cases where victims did not wish to disclose or take further action. Trainers also identified a need for additional content on gender-based violence among teenagers, which could serve as a preventive measure, given that many adult DV victims had prior interactions with mental health services during adolescence.

The thorny problem of content selection (given that trainings are necessarily time-limited) also came up in some of these post-trainings talks, but will be dealt with in more depth in relation to the focus groups (see 5.3.).

5.3. Focus Groups

After pilot trainings were finished, online focus groups were held with trainers from all training locations (Annex 7.10 Trainer consent and contact list). This step in the evaluation process had to be slightly altered vis-à-vis the evaluation strategy due to the fact that finding common dates for bigger groups of trainers proved to be much more difficult than anticipated and that one training in Germany had to be postponed to late April. Both developments mandated flexibility in terms of timing and method. Originally, it had been planned to have two online focus groups with twelve trainers in total taking place in March 2025. In effect, three focus

groups were held (two on 13 March, one 22 April), in which nine trainers from five locations took part. All focus groups were held on zoom and took about 90 minutes. They were complemented by one individual interview covering the sixth training location. Focus groups were intentionally mixed in terms of location as well as in terms of target groups of the trainings in order to allow a focus on possible differences along those two factors. All focus groups and the interview were moderated by IKF following a guideline for questions.

The first focus group consisted of two trainers from Greece and one from Italy (unfortunately a trainer from Germany couldn't take part due to technical issues). In both locations several trainings had been held for medical professionals as well as medical students. In the Italian case trainings were two to four days, encompassing eight to sixteen hours face-to-face interaction, in Greece they were two days with 12 hours face-to-face training time in total. The most notable difference was the number of participants for individual training sessions, which was much higher in Italy with approximately 30 participants in each training for medical professionals and up to approximately 200 students. In Greece 12 to 14 medical professionals and between 9 and 25 students took part in each individual training.[7] The Italian case was special insofar as in contrast to numbers at all other training sites the share of male participants was at 40% among students.

In the second focus group two trainers form Austria and Germany, who had trained medical students, and one trainer from Sweden, who had trained a mixed group of medical professionals including nurses from two different hospitals as well as social workers, took part. The set-up of the trainings differed somewhat: In Austria the two-day-training consisted of a one day 'basic'-training and a 'deep dive' later with 38 students taking part in the first day but significantly fewer attending the 'deep dive'. In Germany the trainer had held two trainings for students at WWU, each lasting a whole weekend, and in which 17 respectively 13 students had taken part. The group of professionals in Sweden was smaller with nine attendants and was held in an eight-hour face-to-face session on one day.

The third group consisted of trainers from Austria, Germany and Italy. In this case, the Austrian training had been for medical doctors, with 14 participants, taking place in one day. The German trainer from WWU had ample experience having done several trainings in the VIPROM-framework, in the course of the discussion mainly referring to three trainings for medical students with groups of around 15 participants' each. These trainings were all held on two consecutive days. As described above trainings in Italy were much larger, with 187 students taking part in the first training and more than 200 showing up for the second one. In this case the trainer worked with two teaching assistants.

Last but not least, an individual interview was held with a trainer from the second German partner (GESINE), who had trained a group of eight nurses-in-training in a one day session.

In the following results are presented by topic rather than by group of interviewees.

5.3.1. Different Stakeholders – Different Needs

Differences between stakeholder groups – e.g. different needs, different preferences in terms of didactic methods and materials – were one of the main topics for the focus groups. The

[7] For a complete description of trainings see Deliverable D4.2. In the following, numbers are reported for individual trainers taking part in the focus groups not for national training efforts in total.

differences discussed among trainers can be grouped in three broad categories: a) differences in recruitment, b) different needs in terms of content due to different backgrounds and experiences, and c) differences in terms of preferred didactic methods.

Differences in recruitment pertain first to the distinction between medical professionals and students. Unsurprisingly, medical professionals with their tight and demanding schedules are harder to recruit than students, whose “job it is to follow classes” as one trainer aptly put it. Especially medical doctors find it difficult to attend long(ish) face-to-face trainings. Discussions around this topic yielded a number of strategies to deal with this difficulty, albeit admittedly none of them proved to be ideal in all respects. One suggestion was to split longer trainings into a series of shorter units which might make attendance less burdensome but at the same time runs the risk that not all participants will be able to attend all parts of the training. Depending on local circumstances and distances in-person attendance on several dates might also be difficult to manage. Another option was to have the input-/knowledge-focussed parts of the training in the form of an online-lecture (including e.g. a Q&A part), which could be recorded, thereby offering more freedom to participants to watch it at their own leisure. This would allow for a comparably short face-to-face part which could focus entirely on interactive methods and skill-development in line with the goals of the VIPROM-trainings. This approach would need testing in real world-conditions as the question remained whether participants would be motivated to do their own preparation in sufficient depth. Quite possibly national differences in habitus concerning professional trainings in the medical sector might play a role in how well such a combination would work.

The relative difficulty of recruiting doctors also touches upon another challenge that any voluntary professional training faces: the fact that those that enlist for the training are highly motivated and interested in the topic, but might not be representative of the profession at large. Trainers from Italy and Greece noted that while participating doctors were highly motivated, they as well as nurses and midwives in other training groups, commented that many of their colleagues were reluctant to engage with cases of DV, deeming it not part of their job, but a task for other professions like social workers. According to these accounts, many doctors lacked empathy – which is also lacking in medical education – and therefore find it hard to approach DV issues, albeit with a younger generation of doctors, change has started. This analysis was echoed by two trainers from Germany. One described how midwives had been talking about experiences of not being taken serious by doctors. The other explained that nurses-in-training were in a different situation than medical students, because already during internships they had a lot of contact with patients, a lot more time for talking with them and – crucially – witnessed visitors and their effects on the patients’ wellbeing.

Another challenge that trainers mentioned in connection with recruitment was the noticeable underrepresentation of men in nearly all training groups, which was more pronounced among professionals than among students. Especially the Italian example with a ratio of approximately 60% female and 40% male students pointed to a possibility of change with the younger generation. Trainers noted that male participants tend to bring different perspectives into the training than their female counterparts which can enrich reflection. While of course part of the explanation can be found in the overrepresentation of women in nursing and midwifery, this does not provide an explanation for the lower interest among male doctors and medical students, which might rather be found in the common perception of DV as a “women’s issue” (which VIPROM is actively trying to correct).

Following from different professional roles, trainers also noted differences between medical doctors and other groups of medical professionals regarding their needs in terms of content

and approaches to the topic of DV, albeit in this context previous knowledge plays an important role and findings cannot be generalized. Yet, especially trainers from Italy and Greece, who had trained both stakeholder groups, noted that doctors were most interested in practical skills in terms of dealing with cases of DV, while nurses and midwives were often eager to learn more about DV in terms of theories and frameworks in order to better be able to analyse past experiences and prepare for future cases. In all cases specialised VIPROM-content e.g. on gynaecology and obstetrics or on dentistry was highly appreciated by participants with especially the latter clearly filling a gap in training options. These differences notwithstanding trainers also noticed that specialisation in terms of medical fields did not matter that much as most questions by participants focussed on the "how" of dealing with DV, i.e. on how to communicate, where to send people, how to document injuries correctly, rather than on treatment or their specific fields of expertise. A focus on communication and the use of screening questions emerged as one central building block as these issues are relevant to everyone working in the medical field.

5.3.2. Didactic Approaches and Methods

It follows from the commonalities just described that the didactic concept of the VIPROM-training with its focus on the creation of a safe space and skill-development (in addition to knowledge-transfer) can in principle remain the same for all stakeholder groups with different foci in terms of content and slight adaptations of material used. The importance of establishing a safe space at the beginning of the training was mentioned repeatedly by trainers. I.a. this allowed trainers to deal with (heated) debates on contested topics in a positive manner.

Clearly the biggest difference in terms of didactics was the importance of scenarios vs. real-world cases and discussions of participants' own experiences, with scenarios being especially instructive for students. The detailed organisation of role plays – whether participants worked on their own in small groups or whether trainers oversaw the whole exercise; whether participants were encouraged to be creative with the scenarios or stick to a pre-defined situation – varied according to settings. In all cases however, trainers noted that the experience of the role-plays needed to be reflected with the groups afterwards, i.e. that it was important to provide time and space for this reflective work to also deal with the emotional effects of this form of exercise.

While differences between professionals and students are to be expected as a result of different amounts of experience as well as familiarity with different didactic tools, it is worth noting that role plays – which can also incorporate real-world scenarios – serve not only as problem-solving exercises, but also as a possibility to practice skills (e.g. in communication) and to foster a change in perspective, e.g. by taking the role of the victim. Given the critical remarks on (some) doctors' lack of empathy, it might therefore be crucial to include these in trainings for medical professionals.

For all stakeholders, the variety of methods used in the trainings and the personal engagement was welcome and refreshing, maybe most of all for medical professionals as it provided a different approach to the more common lecture-oriented style of most professional trainings. Especially the possibility to learn not just from the trainer(s), but also from one's peers was welcomed by participants.

One strategy trainers used to tailor content to participants' needs in student training was to have them do a form of homework (e.g. self-study and research on defined questions), which

had to be handed in before the training. This gave trainers a good impression of students' prior knowledge and allowed them to adapt their presentation accordingly as well as to include examples brought up by the students in their homework. This proved a very fruitful approach for students' trainings, but – as another trainer pointed out – might be difficult for medical professionals, who approach their trainings with a somewhat different mind-set and might not be willing to commit to preparatory work.

Unequivocally, trainers emphasised the need to be flexible and to adjust training plans on the fly if necessary. "As trainers we have to be very well prepared, but we should not rigorously stick to our concepts. It is important to know which issues you definitely want to work on in the training, but apart from those it is important to be flexible in working with participants' needs in order to deliver a good training." Differences between groups became tangible when two trainers in one focus group exchanged their contrasting experience with documentation exercises, which one group found especially interesting, while another group was much less enthusiastic about this specific part of the training.

Among those trainers, who had worked in teams, this cooperation was held in high regards. Not only had it made it easier to hold the trainings (e.g. offering the possibility to accompany several working groups simultaneously), it also offered a greater knowledge pool if trainers came from different specialisations and provided a variety of teaching styles, which participants valued.

5.3.3. Training Platform

All trainers praised the training platform for the richness of content and didactic materials available, which they had used in preparation. For the trainings themselves the platform was used for self-study for participants and some trainers integrated it into the face-to-face training and worked directly with the contents on the platform rather than creating their own slides. But also those that worked with their own slides often mixed in parts of the online-content, e.g. using videos, quizzes or other material in their trainings. In all cases the link to the platform was given to participants for further self-study or later reference if questions arose in practice. Maybe most indicative of the high quality of the platform is the fact that all trainers were positive, that they would keep using the platform for further trainings, even if these trainings were not fully in line with the VIPROM-framework.

One (unavoidable) limitation of a European platform and its national adaptations is of course a lack of *local* information (e.g. phone number of local shelters, specialised local organisations etc.). Therefore, several trainers mentioned that they added this information to the trainings themselves. Others had included their own research in the trainings as they wanted to cover certain topics (e.g. non-verbal communication) in even more depth than the platform provided. These examples testify to the advantages of the flexibility of the VIPROM-framework.

The overwhelmingly positive ratings notwithstanding trainers also noted challenges when working with the platform as even for trainers with a lot of prior experience the switch to the new VIPROM-framework was challenging. "Even though the content is the same [as in previous training following a different framework] it is performed differently." Several trainers mentioned that it was difficult to choose the most suitable topics and exercises from the wealth of material and argued for the inclusion of either, examples of ready-made-trainings within the platform or of (more) short summaries and graphically marked "most important content" to make choosing easier. The ensuing debates clearly showed the need to balance the

conflicting goals of providing ample material for trainers to choose from and keeping the amount of information manageable and user-friendly. Within the VIPROM-project the difficulties arising where handled through the offer of TtT-trainings, which allowed trainers to familiarise themselves with the platform and the didactic approach. In terms of sustainability it will be crucial that the TtT-handbook can be used by prospective trainers as a guide and orientation.

The most important challenge in relation to sustainability will be to keep the platform up to date (e.g. concerning national legal developments) after the end of the VIPROM-project. During the focus groups several trainers urged the project to find a solution for keeping the platform “up to date and relevant”.

5.4. Interim Conclusions

Summing up trainers’ responses after their training we see overwhelmingly positive impressions, with little differences between trainings for professionals and trainings for students.

Especially the wealth of material and the diversity of methods, which allowed trainers to “pick and choose” and handle the training with high flexibility were remarked upon favourably, as were the diverse didactic methods that kept participants’ engagement high (experiential learning, role play etc.). Especially for medical professionals but also for some student groups the exchange of individual experiences was a corner stone of the training experience. But it also became clear that this way of teaching also meant that trainers had to deal with participants’ emotions and potential frustration. This might be one reason to hold VIPROM-trainings in a team-teaching setting whenever possible. In conclusion, effects of the trainings in the form of a new understanding of the medical sector’s potential role and the networking efforts among participants oriented towards sustainable engagement, show training success beyond reaching knowledge-focused learning goals.

The focus groups also revealed a very positive stance towards the VIPROM-trainings by trainers in all partner countries in hindsight. The didactic approach with its focus on the creation of a safe space, open exchange among participants, hands-on training methods and spaces for reflection worked well with different groups of stakeholders. Role plays and scenario work emerged as central didactic tools. Flexibility in terms of trainees’ needs was another core principle, which all trainers ascribed to. For those who had experienced it, team-teaching remained a fruitful and experience was recommended for future trainings.

Challenges in terms of recruitment of participants were noted mainly in relation to medical doctors, whose tight schedules make it difficult to take part in longer trainings. This structural difficulty can of course not be resolved by the VIPROM-project, but there were a number of suggestions in order to deal with the issue, including hybrid formats as well as splitting the training into a series of shorter sessions. As all of these options present their own challenges and they have not been systematically piloted in the framework of the project further experiences will be necessary. Trainers weighed the pros and cons of shorter and longer trainings. Especially in connection with the aim of broadening participation – e.g. reaching doctors, who are not yet fully engaged in the topic of DV and therefore might not be ready to spend e.g. a full weekend – shorter consecutive trainings might be an option, yet are carrying the risk of participants skipping parts of the content. The difficulty of this issue becomes even more obvious, as participants in their feedback as well as trainers themselves tended to

suggest further content even after a 2-day training session, rather than pointing to options for reduction.

The platform itself was also highly praised for the wealth of material it offered, even though it also presented challenges as picking the most relevant topics and exercises for the different groups proved time-consuming and difficult resulting in a high workload in the preparation of the VIPROM-trainings. Partly, this can be explained as an effect of the "pilot"-stage of trainings, where most trainers worked with the platform, the material and the didactic concept for the first time. It might be argued that the effort for preparation will go down once trainers are intimately familiar with the training platform. Still, the fact remains that there is a trade-off between the richness of material and the efficacy of training preparation. In terms of sustainability two important challenges arise in this regard. First, TtT-trainings that offered input on how to work with the platform were of high importance, but might be difficult to provide after the end of the VIPROM-projects. Tools like the TtT-handbook will therefore become even more relevant. It might be prudent to pick up some trainers' suggestions of offering examples of trainings (e.g. including estimates for the time needed for specific exercises) or marking the most important content more clearly in order to facilitate the planning process. Second, the platform itself needs to be kept up to date, i.e. adapted to changes in national legislation or institutional regulations.

Last but not least, trainers also formulated recommendations beyond the current scope of the VIPROM-project including a broadening of target groups to include e.g. also administrative staff in hospitals and training obligations for students and professionals alike. These recommendations point towards the need to further institutionalize the VIPROM-trainings.

6. Conclusions and Recommendations

In summary, the evaluation clearly paints an overwhelmingly positive picture of the VIPROM-trainings from all perspectives that could be taken into account (participants, trainers, observers).

Results obtained by all methods of data generation used in the evaluation point out that

a) trainings provided an interesting and positive learning experience for the different (groups of) participants,
b) were effective in transmitting knowledge and relevant skills in dealing with DV and
c) provided practically applicable and therefore sustainable learnings.

There was equally broad consensus that training success rested not only on trainers' individual expertise (of course an important prerequisite), but also on the didactic set-up of the VIPROM-trainings. A number of factors can be discerned in this respect, among them

a) the focus on stakeholder needs and trainers' ability to tailor trainings beforehand *and* to react flexibly on the spot;
b) the creation of a safe space, which allowed participants to talk freely and even voice insecurities;
c) didactic variety and the use of interactive methods and experiential learning according the groups' needs as well as
d) the orientation towards agency and possibilities for change in stakeholders' areas of work and their institutions.

The evaluation showed a measurable positive connection between trainers' use of a variety of didactic and interactive methods, participants' knowledge gains and applicability of training contents in daily practice. Observations also highlighted less easily measurable factors like the use of breaks for networking among participants, which has the potential to strengthen the sustainability of changes in individual as well as institutional practices. Socio-demographic characteristics among medical professionals participating in the VIPROM-trainings pointed to the fact that training on DV is needed not only among students and young doctors and nurses, but that experienced medical professionals also profit immensely, even though their level of knowledge was already higher before the VIPROM-trainings.

In this sense most results do not point towards recommendations for change but rather towards recommendations to stick with the VIPROM-principles in terms of didactic approaches. Results are especially pronounced in terms of the positive effects of the creation of safe spaces, the usefulness of interactive methods and the general orientation towards agency.

From trainers' perspectives it has been noted that this approach and the free exchange of ideas and experiences also entails that trainers might have to deal with participants' emotions. This point (besides more general arguments, e.g. the bundling of expertise) provided a strong argument for why VIPROM-trainings seem to be best delivered in a team-teaching setting.

Yet, these positive results of the evaluation notwithstanding some challenges remain. A number of those challenges relate to recruitment of participants. First, at all training sites and across all training groups women far outnumbered men among trainers as well as participants. The framing of DV as a "women's issue" is of course a broader problem that cannot be tackled by a single project or by one training curriculum, but still a number of recommendations might be formulated: It will be important for all further trainings to keep the focus on the diversity of (potential) victims. Possibly, even more emphasis can be put on men's agency in supporting victims of DV when communicating about the trainings. Yet this has to be balanced with the need to also teach about the gendered nature of the phenomenon of DV itself.

Trainers noted challenges in terms of recruitment mainly in relation to medical doctors, whose tight schedules make it difficult to take part in longer trainings. Again, this is a structural difficulty, which cannot be resolved by any one project, but there were a number of suggestions in order to deal with the issue. The main point of discussion were options for offering different training formats when delivering the VIPROM-content, including hybrid formats as well as splitting the training into a series of shorter sessions. As all of these options present their own challenges and as they have not been systematically piloted in the framework of the VIPROM-project no clear evidence-based recommendation can be formulated in this regard. Shorter consecutive trainings might provide a possibility to broaden participation, yet are carrying the risk of participants skipping parts of the content. Hybrid trainings could provide more flexibility, yet run the risk of participants feeling overwhelmed by the need for self-study in preparation. It seems clear that there will be no one-size fits all solution to this issue, but that further institutionalisation of the VIPROM-curriculum would be a key step.

Trainers themselves partly felt challenged by the pilot trainings as they needed to choose not only didactic tools but also focus topics for each group from the wealth of VIPROM-material available on the training platform. Trainers' feedback on the platform was therefore somewhat ambivalent as the amount of material and the depth of information was highly praised on the one hand side, and deemed problematic due to the high workload it caused in preparation on the other hand side. Partly, this can be explained as an effect of the "pilot"-stage of trainings,

where most trainers worked with the platform, the material and the didactic concept for the first time. It might be assumed that the effort for preparation will go down once trainers are intimately familiar with the training platform. Still, the fact remains that there is a trade-off between the richness of material and the efficacy of training preparation. This aspect might even play a bigger role in the future, if new trainers might have to rely on written guidance (especially the TtT-handbook) rather than receiving full face-to-face TtT-trainings.

While institutionalising TtT-trainings in a comprehensive fashion would of course be the best solution – and is therefore highly recommended – promoting the TtT-handbook as an essential tool for comprehensive work with the VIPROM-platform seems highly relevant in the short term. It might also be prudent to pick up some trainers' suggestions of offering examples for training-design (e.g. including a possible time-schedule for a training-session) on the platform itself.

Concerning the platform a second challenge is of course that the modules themselves need to be kept up to date even after the end of the VIPROM-project, i.e. they need to be adapted to changes in national legislation, new international regulations or changed practices.

Last but not least, taking results on the VIPROM-project as a starting point two major recommendations for further work against DV in the medical sector can be formulated: First, a broadening of target groups to include e.g. also administrative staff in hospitals would be highly recommended; second, further institutionalisation of the DV-trainings is a necessity. This means that comprehensive DV-trainings should become obligatory for medical students and medical professionals alike throughout Europe in order to further the change that VIPROM helped start.

7. Annexes

7.1. Annex 1: Questionnaire medical professionals Q1

Pre-Training Survey for Medical Professionals

This survey is part of the EU-funded VIPROM (Victim Protection in Medicine) project, which aims to improve support for victims of domestic violence in the medical sector. To achieve this goal we developed specific training concepts and an online-platform, which you get to know in this training.

We need your valuable support so that we can continue to improve our training courses and materials! Your opinion counts – by completing three short questionnaires (one now, one directly after the training and one after six months), you will help us to tailor the training to your needs and those of future participants.

Participation in the survey is voluntary and anonymous. Your data will be analysed in aggregated form only and you may opt out of the survey at any time without any consequences.

The survey takes about 5 minutes to complete.

Thank you in advance for your time and your valuable insights!

General questions

Please create an individual person code so that we can compare the surveys anonymously before and after the course.

1st digit: First letter of your first name (e.g. Kate - K)

2nd and 3rd digit: Month of your birth (e.g. August - 08)

4th digit: First letter of your place of birth (e.g. Berlin - B)

Personal Code:	

Gender (please mark the correct answer):	
Female	
Male	
Diverse/non-binary/queer	
Other (please specify):	

Age (in years):	

What applies to you?	
Doctor	
Nurse	
Midwife	
Other (please specify):	

How long have you worked in hospitals in total?	
0-1 year	
1-5 years	
5-10 years	
More than 10 years	
I don't work in a hospital/not applicable	

Have you encountered cases of domestic violence among patients in the hospital in the last 12 months?	
Yes	
No	
Not applicable	

Domestic Violence

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	

On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

	1-10
I know the most common forms of domestic violence.	
I know about the main risk factors for domestic violence.	
I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	
I have the tools to identify domestic violence and assess risks.	
I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	
I know about services, advice and support centres for victims of domestic violence in my area.	
I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	

On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

	1-10
It is easy for me to talk to patients about domestic violence.	
I recognise indicators for domestic violence.	
I can carry out a risk assessment and derive measures from it.	
I routinely include screening questions about domestic violence in my conversations with patients.	
I know when and how to refer (potential) victims of domestic violence to further/specialized counselling and support services.	
I have practice in creating documentation of injuries caused by domestic violence that can be used in court.	

Which of the following statements are correct?

Please mark all correct answers in the field below. There may be more than one correct answer to each question. Please give your honest assessment. All results are completely anonymous - the test does not evaluate you, but the quality of the training!

Which persons/groups are victims or perpetrators of domestic violence?			
There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	Perpetrators of violence are often charming and friendly in demeanour.	Domestic violence is a problem of backward cultures.
(…)	(…)	(…)	(…)

In which of the following situations is there an increased risk of domestic violence			
During pregnancy	During and after a separation or divorce	During university	At a disco, clubbing or similar events
(…)	(…)	(…)	(…)

Under what circumstances should healthcare professionals ask patients about domestic violence?			
All patients should be routinely asked about domestic violence.	Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	Patients with noticeable haematomas or similar injuries should be asked about domestic violence, regardless of the reason for the visit.	Private issues should only be addressed if patients themselves indicate relationship problems.
(…)	(…)	(…)	(…)

What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?			
It is not ideal, but acceptable, if relatives or children of the patient translate.	It is important not to enter into the conversation with preconceptions about victims and perpetrators.	If an accompanying person is present, he/she should be included in the conversation.	If patients are not willing to talk about the situation, this should be accepted.

(…)	(…)	(…)	(…)

Do you have any comments on the survey or is there anything else you would like to tell us?

7.2. Annex 2: Questionnaire medical professionals Q2

Post-Training Survey for Medical Professionals

After completing the training, we ask you to kindly fill in a short questionnaire and give us feedback on your training experience. This will help us to further improve our efforts!

Thank you very much

It takes about 10 minutes to complete the survey.

General questions

Please create an individual person code so that we can compare the surveys anonymously before and after the course.

1st digit: First letter of your first name (e.g. Kate - K)

2nd and 3rd digit: Month of your birth (e.g. August - 08)

4th digit: First letter of your place of birth (e.g. Berlin - B)

Personal Code:	

Have you filled in the pre-training survey?	
yes	
no	

If yes please go directly to the questions about the training (page 3), if not please answer the following questions:

Gender (please mark the correct answer):	
Female	
Male	
Diverse/non-binary/queer	
Other (please specify):	
Age (in years):	

What applies to you?	
Doctor	
Nurse	
Midwife	
Other (please specify):	

How long have you worked in hospitals in total?	
0-1 year	
1-5 years	
5-10 years	
More than 10 years	
I don’t work in a hospital/not applicable	

Have you encountered cases of domestic violence among patients in the hospital in the last 12 months?	
Yes	
No	
Not applicable	

Questions about the training

Structure/Timeframe of the training (Please fill in the approximate duration and timeframe)

The training I attended included approx. _____ hours of in-person training and _____ hours of self-study.

Didactics

Which methods were used in the training you attended? (Check all that apply)	
Input/lecture	
Group work/group discussion	
Videos	
(Self-)Assessment	
Case Studies	
Simulations	
Role Play	
Other (please specify):	

On a scale from 1 (lacking) to 10 (very high): Please now rate some aspects of the training you attended.

	1-10
Overall quality of the training	
Structure of the training	
Presentation of the content and teaching methods	
Expertise of the trainers	
Methodological and didactic competence of the trainers	
Relevance for working with victims of domestic violence in hospitals	

On a scale from 1 (strongly disagree) to 10 (strongly agree): How much do you agree with the following statements?

	1-10
I can apply the content of the training in my area of work.	
After the training, I know (even) more about domestic violence	
As a result of the training, I feel (even) more confident talking to patients about domestic violence.	
The training makes it easier for me to raise the topic of DV with colleagues in the hospital .	

Feedback – Please note down some key words

What did you particularly like about the training?
What else would you have liked to see in the training?

Domestic Violence

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate the impact of the course you just took part in on your knowledge?	

On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

	1-10
I know the most common forms of domestic violence.	
I know about the main risk factors for domestic violence.	
I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	
I have the tools to identify domestic violence and assess risks.	
I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	
I know about services, advice and support centres for victims of domestic violence in my area.	
I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	

On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

	1-10
It is easy for me to talk to patients about domestic violence.	
I recognise indicators for domestic violence.	
I can carry out a risk assessment and derive measures from it.	

I routinely include screening questions about domestic violence in my conversations with patients.	
I know when and how to refer (potential) victims of domestic violence to further/specialized counselling and support services.	
I have practice in creating documentation of injuries caused by domestic violence that can be used in court.	

Which of the following statements are correct?

Please mark all correct answers in the field below. There may be more than one correct answer to each question. Please give your honest assessment. All results are completely anonymous - the test does not evaluate you, but the quality of the training!

Which persons/groups are victims or perpetrators of domestic violence?			
There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	Perpetrators of violence are often charming and friendly in demeanour.	Domestic violence is a problem of backward cultures.
(…)	(…)	(…)	(…)

In which of the following situations is there an increased risk of domestic violence			
During pregnancy	During and after a separation or divorce	During university	At a disco, clubbing or similar events
(…)	(…)	(…)	(…)

Under what circumstances should healthcare professionals ask patients about domestic violence?			
All patients should be routinely asked about domestic violence.	Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	Patients with noticeable haematomas or similar injuries should be asked about domestic violence, regardless of the reason for the visit.	Private issues should only be addressed if patients themselves indicate relationship problems.
(…)	(…)	(…)	(…)

What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?			
It is not ideal, but acceptable, if relatives or children of the patient translate.	It is important not to enter into the conversation with preconceptions about victims and perpetrators.	If an accompanying person is present, he/she should be included in the conversation.	If patients are not willing to talk about the situation, this should be accepted.

(…)	(…)	(…)	(…)

Do you have any comments on the survey or is there anything else you would like to tell us?

7.3. Annex 3: Questionnaire medical professionals Q3

Survey for Medical Professionals Six Months After Training

Six months ago you took part in training on domestic violence in the framework of the VIPROM-project (Victim protection in medicine). We now kindly ask you to fill in a final short questionnaire, which will help us to further improve our efforts!

Thank you very much

It takes about 8 minutes to complete the survey.

General questions

Please create an individual person code so that we can compare the surveys anonymously before and after the course.

1st digit: First letter of your first name (e.g. Kate - K)

2nd and 3rd digit: Month of your birth (e.g. August - 08)

4th digit: First letter of your place of birth (e.g. Berlin - B)

Personal Code:	

Have you already filled in a VIPROM training survey? (Before and/or after the training)	
yes	
no	

Gender (please mark the correct answer):	
Female	
Male	
Diverse/non-binary/queer	
Other (please specify):	

Age (in years):	

What applies to you?	
Doctor	
Nurse	
Midwife	
Other (please specify):	

How long have you worked in hospitals in total?	
0-1 year	
1-5 years	
5-10 years	
More than 10 years	
I don’t work in a hospital/not applicable	

Have you encountered cases of domestic violence among patients in the hospital in the last 12 months?	
Yes	
No	
Not applicable	

Questions about the training

Please think about the VIPROM-training on domestic violence. Which three key words come to your mind?

1. _____

2. _____

3. _____

On a scale from 1 (lacking) to 10 (very good): In hindsight, please rate some aspects of the training you attended.

	1-10
Overall quality of the training	
Structure of the training	
Presentation of the content and teaching methods	
Expertise of the trainers	
Methodological and didactic competence of the trainers	
Relevance for working with victims of domestic violence in hospitals	

Are there any aspects (contents, methods…) that you remember especially well? Please list 2 to 5 keywords

_____

On a scale from 1 (strongly disagree) to 10 (strongly agree): How much do you agree with the following statements?

	1-10
I can apply the content of the training in my area of work.	
The training has reassured me in some aspects of my approach and communication with victims of domestic violence.	
The training has positively changed some aspects of my approach and communication with victims of domestic violence.	
After the training, I know more about domestic violence.	
As a result of the training, I feel more confident talking to patients about domestic violence.	
The training makes it easier for me to raise the topic of domestic violence with colleagues in the hospital .	
The training supports my efforts in driving forward changes in my area of work that benefit victims of domestic violence.	

Feedback – please note down some key words

How can you use the training in your work today? What has changed as a result?
What else would you like to see? What additional information or training do you see a need for?

Domestic Violence

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate the impact of the training you just took part in on your knowledge?	

On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

	1-10
I know the most common forms of domestic violence.	
I know about the main risk factors for domestic violence.	
I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	
I have the tools to identify domestic violence and assess risks.	
I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	
I know about services, advice and support centres for victims of domestic violence in my area.	
I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	

On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

	1-10
It is easy for me to talk to patients about domestic violence.	
I recognise indicators for domestic violence.	

I can carry out a risk assessment and derive measures from it.	
I routinely include screening questions about domestic violence in my conversations with patients.	
I know when and how to refer (potential) victims of domestic violence to further/specialized counselling and support services.	
I have practice in creating documentation of injuries caused by domestic violence that can be used in court.	

Which of the following statements are correct?

Please mark all correct answers in the field below. There may be more than one correct answer to each question. Please give your honest assessment. All results are completely anonymous - the test does not evaluate you, but the quality of the training!

Which persons/groups are victims or perpetrators of domestic violence?			
There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	Perpetrators of violence are often charming and friendly in demeanour.	Domestic violence is a problem of backward cultures.
(…)	(…)	(…)	(…)

In which of the following situations is there an increased risk of domestic violence			
During pregnancy	During and after a separation or divorce	During university	At a disco, clubbing or similar events
(…)	(…)	(…)	(…)

Under what circumstances should healthcare professionals ask patients about domestic violence?			
All patients should be routinely asked about domestic violence.	Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	Patients with noticeable haematomas or similar injuries should be asked about domestic violence, regardless of the reason for the visit.	Private issues should only be addressed if patients themselves indicate relationship problems.
(…)	(…)	(…)	(…)

What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?			
It is not ideal, but acceptable, if relatives or children of the patient translate.	It is important not to enter into the conversation with preconceptions about victims and perpetrators.	If an accompanying person is present, he/she should be included in the conversation.	If patients are not willing to talk about the situation, this should be accepted.

(…)	(…)	(…)	(…)

Do you have any comments on the survey or is there anything else you would like to tell us?

7.4. Annex 4: Questionnaire students Q1

Pre-Course Survey for Students

This survey is part of the EU-funded VIPROM (Victim Protection in Medicine) project, which aims to improve support for victims of domestic violence in the medical sector. To achieve this goal we developed specific training concepts and an online-platform, which you get to know in this course.

We need your valuable support so that we can continue to improve our training courses and materials! Your opinion counts – by completing three short questionnaires (one now, one directly after the training and one after six months), you will help us to tailor the training to your needs and those of future participants.

Participation in the survey is voluntary and anonymous. Your data will be analysed in aggregated form only and you may opt out of the survey at any time without any consequences.

The survey takes about 5 minutes to complete.

Thank you in advance for your time and your valuable insights!

General questions

Please create an individual personal code so that we can compare the surveys anonymously before and after the course.

1st digit: First letter of your first name (e.g. Kate - K)

2nd and 3rd digit: Month of your birth (e.g. August - 08)

4th digit: First letter of your place of birth (e.g. Berlin - B)

Personal Code:	

Gender (please mark the correct answer):	
Female	
Male	
Diverse/non-binary/queer	
Other (please specify):	

Age (in years):	

Have you already been working in a hospital (e.g. practice)?	
Yes	
No	

Have you encountered cases of domestic violence among patients in the hospital?	
Yes	
No	
Not applicable	

Domestic violence

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	

On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

	1-10
I know the most common forms of domestic violence.	
I know about the main risk factors for domestic violence.	
I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	
I have the tools to identify domestic violence and assess risks.	
I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	
I know about services, advice and support centres for victims of domestic violence in my area.	

I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	

On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

	1-10
Dealing with domestic violence has been a relevant topic in my studies to date.	
I know indicators for domestic violence.	
I feel competent to communicate with victims of domestic violence.	
I know examples of screening questions about domestic violence and how to pose them in an appropriate and respectful manner.	
I know referral procedures to specialised counselling and support services for victims of domestic violence.	
I can perform documentations of injuries caused by domestic violence that can be used in court.	

Which of the following statements are correct?

Please mark all correct answers in the field below. There may be more than one correct answer to each question. Please give your honest assessment. All results are completely anonymous – the test does not evaluate you, but the quality of the course!

Which persons/groups are victims or perpetrators of domestic violence?			
There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	Perpetrators of violence are often charming and friendly in demeanour.	Domestic violence is a problem of backward cultures.
(…)	(…)	(…)	(…)

In which of the following situations is there an increased risk of domestic violence			
During pregnancy	During and after a separation or divorce	During university	At a disco, clubbing or similar events
(…)	(…)	(…)	(…)

Under what circumstances should healthcare professionals ask patients about domestic violence?			
All patients should be routinely asked about domestic violence.	Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	Patients with conspicuous injuries or behaviour should be asked about domestic violence, regardless of the reason for their visit.	Private issues should only be addressed if patients themselves indicate relationship problems.
(…)	(…)	(…)	(…)

What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?			
It is not ideal, but acceptable, if relatives or children of the patient translate.	It is important not to enter into the conversation with preconceptions about victims and perpetrators.	If an accompanying person is present, he/she should be included in the conversation.	If patients are not willing to talk about the situation, this should be accepted.
(…)	(…)	(…)	(…)

Do you have any comments on the survey or is there anything else you would like to tell us?

7.5. Annex 5: Questionnaire students Q2

Survey for Students after the Course

After completing the course, we ask you to kindly fill in a short questionnaire and give us feedback on your course experience. This will help us to further improve our efforts!

Thank you very much

It takes about 10 minutes to complete the survey.

General questions

Please create an individual personal code so that we can compare the surveys anonymously before and after the course.

1st digit: First letter of your first name (e.g. Kate - K)

2nd and 3rd digit: Month of your birth (e.g. August - 08)

4th digit: First letter of your place of birth (e.g. Berlin - B)

Personal Code:	

A2. Have you filled in the pre-course survey?	
yes	
no	

If yes please go directly to the questions on the course (page 3), if not please answer the following questions:

Gender (please mark the correct answer):	
Female	
Male	
Diverse/non-binary/queer	
Other (please specify):	

Age (in years):	

Have you already been working in a hospital (e.g. practice)?	
Yes	
No	

Have you encountered cases of domestic violence among patients in the hospital?	
Yes	
No	
Not applicable	

Questions about the course

Structure/Timeframe of the course (Please fill in the approximate duration and timeframe)

The course I attended included approx. _____ hours of in-person training and _____ hours of self-study.

Didactics

Which methods were used in the course you attended? (Check all that apply)	
Input/lecture	
Group work/group discussion	
Videos	
(Self-)Assessment	
Case Studies	
Simulations	
Role Play	

Other (please specify)

On a scale from 1 (lacking) to 10 (very high): Please now rate some aspects of the course you attended.

	1-10
Overall quality of the course	
Structure of the course	
Presentation of the content and teaching methods	
Expertise of the trainers/teachers	
Methodological and didactic competence of the trainers/teachers	
Relevance in the framework of university course work	

On a scale from 1 (strongly disagree) to 10 (strongly agree): How much do you agree with the following statements?

	1-10
I can connect the content of the course to other areas of my university course work.	
After the course, I know more about domestic violence.	
As a result of the course, I feel more confident talking to patients about domestic violence.	
The course makes it easier for me to raise the topic of domestic violende with colleagues at university or at the hospital.	
The course provided important content and training, which was lacking from other university course work.	

Feedback – please note down some key words

What did you particularly like about the course?

What else would you have liked to see in the course?

Domestic violence

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate the impact of the course you just took part in on your knowledge?	

On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

	1-10
I know the most common forms of domestic violence.	
I know about the main risk factors for domestic violence.	
I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	
I have the tools to identify domestic violence and assess risks.	
I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	
I know about services, advice and support centres for victims of domestic violence in my area.	
I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	

On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

	1-10
I know indicators for domestic violence.	
I feel competent to communicate with victims of domestic violence.	
I know examples of screening questions about domestic violence and how to pose them in an appropriate and respectful manner.	
I know referral procedures to specialised counselling and support services for victims of domestic violence.	
I can perform documentations of injuries caused by domestic violence that can be used in court.	

Which of the following statements are correct?

Please mark all correct answers in the field below. There may be more than one correct answer to each question. Please give your honest assessment. All results are completely anonymous – the test does not evaluate you, but the quality of the course!

Which persons/groups are victims or perpetrators of domestic violence?			
There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	Perpetrators of violence are often charming and friendly in demeanour.	Domestic violence is a problem of backward cultures.
(…)	(…)	(…)	(…)

In which of the following situations is there an increased risk of domestic violence			
During pregnancy	During and after a separation or divorce	During university	At a disco, clubbing or similar events
(…)	(…)	(…)	(…)

Under what circumstances should healthcare professionals ask patients about domestic violence?			
All patients should be routinely asked about domestic violence.	Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	Patients with conspicuous injuries or behaviour should be asked about domestic violence, regardless of the reason for their visit.	Private issues should only be addressed if patients themselves indicate relationship problems.
(…)	(…)	(…)	(…)

What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?			
It is not ideal, but acceptable, if relatives or children of the patient translate.	It is important not to enter into the conversation with preconceptions about victims and perpetrators.	If an accompanying person is present, he/she should be included in the conversation.	If patients are not willing to talk about the situation, this should be accepted.
(…)	(…)	(…)	(…)

Do you have any comments on the survey or is there anything else you would like to tell us?

7.6. Annex 6: Questionnaire students Q3

Survey for Students Six Months after the Course

Six months ago you took part in a course on domestic violence in the framework of the VIPROM-project (Victim Protection in Medicine). We now kindly ask you to fill in a final short questionnaire, which will help us to further improve our efforts!

Thank you very much

It takes about 8 minutes to complete the survey.

General questions

Please create an individual personal code so that we can compare the surveys anonymously before and after the course.

1st digit: First letter of your first name (e.g. Kate - K)

2nd and 3rd digit: Month of your birth (e.g. August - 08)

4th digit: First letter of your place of birth (e.g. Berlin - B)

Personal Code:	

A2. Have you already filled in a VIPROM survey? (Before and/or after the course)	
yes	
no	

Gender (please mark the correct answer):	
Female	
Male	
Diverse/non-binary/queer	
Other (please specify):	

Age (in years):	

Have you already been working in a hospital (e.g. practice)?	
Yes	
No	

Have you encountered cases of domestic violence among patients in the hospital?	
Yes	
No	
Not applicable	

Questions about the course

Please think about the VIPROM-course on domestic violence, which three key words come to your mind?

1. _____

2. _____

3. _____

On a scale from 1 (very bad) to 10 (very good): In hindsight, please rate some aspects of the training you attended.

	1-10
Overall quality of the training	
Structure of the training	
Presentation of the content and teaching methods	
Expertise of the trainers	
Methodological and didactic competence of the trainers	
Relevance in the framework of university course work	

Are there any aspects (contents, methods…) that you remember especially well? Please list 2 to 5 keywords

_____

On a scale from 1 (strongly disagree) to 10 (strongly agree): How much do you agree with the following statements?

	1-10
The contents of the course relate to other areas of my university studies	
After the training, I know more about domestic violence	
As a result of the training, I feel more confident talking to patients about domestic violence	
The training makes it easier for me to raise the topic of domestic violence with colleagues at university or in the hospital	

Feedback – please note down some key words

In hindsight, what did you like most about the course? Which contents proofed to be most important?
In hindsight, was there anything missing? Are there any topics or methods you wished you had learned more about?

Domestic violence

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	

	1-10
On a scale from 1 (none) to 10 (very high): How would you rate the impact of the course you just took part in on your knowledge?	

On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

	1-10
I know the most common forms of domestic violence.	
I know about the main risk factors for domestic violence.	
I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	
I have the tools to identify domestic violence and assess risks.	
I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	
I know about services, advice and support centres for victims of domestic violence in my area.	
I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	

On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

	1-10
I know indicators for domestic violence.	
I feel competent to communicate with victims of domestic violence.	
I know examples of screening questions about domestic violence and how to pose them in an appropriate and respectful manner.	
I know referral procedures to specialised counselling and support services for victims of domestic violence.	
I can perform documentations of injuries caused by domestic violence that can be used in court.	

Which of the following statements are correct?

Please mark all correct answers in the field below. There may be more than one correct answer to each question. Please give your honest assessment. All results are completely anonymous – the test does not evaluate you, but the quality of the course!

Which persons/groups are victims or perpetrators of domestic violence?			
There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	Perpetrators of violence are often charming and friendly in demeanour.	Domestic violence is a problem of backward cultures.
(…)	(…)	(…)	(…)

In which of the following situations is there an increased risk of domestic violence			
During pregnancy	During and after a separation or divorce	During university	At a disco, clubbing or similar events
(…)	(…)	(…)	(…)

Under what circumstances should healthcare professionals ask patients about domestic violence?			
All patients should be routinely asked about domestic violence.	Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	Patients with conspicuous injuries or behaviour should be asked about domestic violence, regardless of the reason for their visit.	Private issues should only be addressed if patients themselves indicate relationship problems.
(…)	(…)	(…)	(…)

What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?			
It is not ideal, but acceptable, if relatives or children of the patient translate.	It is important not to enter into the conversation with preconceptions about victims and perpetrators.	If an accompanying person is present, he/she should be included in the conversation.	If patients are not willing to talk about the situation, this should be accepted.
(…)	(…)	(…)	(…)

Do you have any comments on the survey or is there anything else you would like to tell us?

7.7. Annex 7: Code book for Partners

Victim Protection in Medicine

Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence

WP5: Codebook for Training-Participant Surveys

Contents

Introduction to the Codebook

The codebooks offer detailed instructions on the reporting of quantitative results from the VIPROM pre- and post-training surveys among medical professionals as well as students in the two templates (Excel-file: VIPROM_WP5_TEMPLATE_ReportingSurveys.xls – Tabs 1 to 4). Open questions are to be reported in a brief narrative report (see template Word-file: VIPROM_WP5_TEMPLATE_ReportingOpenFields.docx). Please note: for the analysis of training effectivity it is **vital to report pre- and post-results as well as results for medical professionals and students separately**, even though we partly asked the same questions. Hence, you will find four different tabs in the excel files for these four different groups of results. The codebooks explain how the answers from survey participants are to be 'translated' to numbers, which are to be reported in the excel-forms. Please make sure to use the correct excel-sheet (pre- or post-training, students or medical professionals) for each group of results. In the excel file each question (identified by its number, e.g. A.1 or B.2.a etc.) has its own column, each participants' answers are to be reported in one row.

	A	B	C	D	E	F	G	
1		A.1.pre Personal Code	A.2.pre Gende	A.3.pre Age	A.4.pre Profession	A.5.pre Work expe	A.6.pre Cases of DV	B.1.pr
2	1	X08B	1	43	2	2	2	
3	2	fill in one row per participant		Identifier for variables (see codebook)				
4	3				see Codebook for "translation" of answers to numbers			
5	4							
6	5							
7	6							
8	7							

As always if you have any questions. Please get in touch: [E-Mail]

Codebook Pre-Training Survey for Medical Professionals

A) General questions

A.1) Personal Code:	'Unique Code given by participant'
A.2) Gender	Female=1 Male=2 Diverse/non-binary/queer=3 Other=4 Missing value=99
A.3) Age (in years):	'Number given by participant' Missing value=99
A.4) What applies to you?	Doctor=1 Nurse=2 Midwife=3 Psychologist=4 Other=5 Missing value=99
A.5) How long have you worked in hospitals in total?	0-1 years=1 1-5 years=2 5-10 years=3 More than 10 years=4 Not applicable=77 Missing value=99
A.6) Have you encountered cases of domestic violence among patients in the hospital in the last 12 months?	Yes=1 No=2 Not applicable=77 Missing value=99

B) Domestic Violence

B.1) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	'Number given by participant' Missing value=99

B.2) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

a) I know the most common forms of domestic violence.	'Number given by participant' Missing value=99
b) I know about the main risk factors for domestic violence.	'Number given by participant' Missing value=99
c) I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	'Number given by participant' Missing value=99

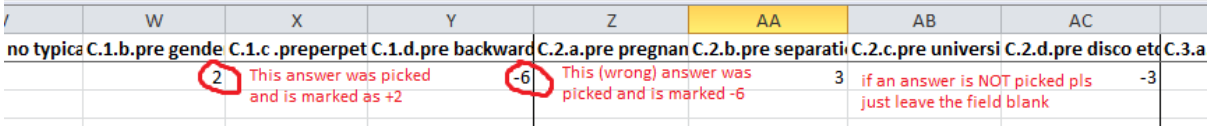
d) I have the tools to identify domestic violence and assess risks.	'Number given by participant' Missing value=99
e) I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	'Number given by participant' Missing value=99
f) I know about services, advice and support centres for victims of domestic violence in my area.	'Number given by participant' Missing value=99
g) I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	'Number given by participant' Missing value=99

B.3) On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

a) It is easy for me to talk to patients about domestic violence.	'Number given by participant' Missing value=99
b) I recognise indicators for domestic violence.	'Number given by participant' Missing value=99
c) I can carry out a risk assessment and derive measures from it.	'Number given by participant' Missing value=99
d) I routinely include screening questions about domestic violence in my conversations with patients.	'Number given by participant' Missing value=99
e) I know when and how to refer (potential) victims of domestic violence to further/specialized counselling and support services.	'Number given by participant' Missing value=99
f) I have practice in creating documentation of injuries caused by domestic violence that can be used in court.	'Number given by participant' Missing value=99

C) Which of the following statements are correct?

Note to coders: *This part of the survey is a multiple-choice-assessment. Participants get a score (positive or negative) for each answer they have chosen. Please only report the answers, which have been picked.* ***If an answer has not been chosen by the participant please leave the respective field BLANK****:*



C.1) Which persons/groups are victims or perpetrators of domestic violence?

a) There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	+2

b) Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	+2
c) Perpetrators of violence are often charming and friendly in demeanour.	+2
d) Domestic violence is a problem of backward cultures.	-6

C.2) In which of the following situations is there an increased risk of domestic violence?

a) During pregnancy	+3
b) During and after a separation or divorce	+3
c) During university	-3
d) At a disco, clubbing or similar events	-3

C.3) Under what circumstances should healthcare professionals ask patients about domestic violence?

a) All patients should be routinely asked about domestic violence.	+5
b) Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	-3
c) Patients with conspicuous injuries or behaviour should be asked about domestic violence, regardless of the reason for their visit.	+1
d) Private issues should only be addressed if patients themselves indicate relationship problems.	-3

C.4) What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?

a) It is not ideal, but acceptable, if relatives or children of the patient translate.	-3
b) It is important not to enter into the conversation with preconceptions about victims and perpetrators.	+3
c) If an accompanying person is present, he/she should be included in the conversation.	-3
d) If patients are not willing to talk about the situation, this should be accepted.	+3

Codebook Post-Training Survey for Medical Professionals

A) General questions

A.1) Personal Code:	'Unique Code as given by participant'
A.2) Have you filled in the pre-training survey	Yes=1 No=2

Note to coders: *If "yes" please leave the rest of the fields in the A) section* ***BLANK****. If "no" please fill them in (including the 99 for missing values).*

A.3) Gender	Female=1 Male=2 Diverse/non-binary/queer=3 Other=4 Missing value=99
A.4) Age (in years):	'Number given by participants' Missing value=99
A.5) What applies to you?	Doctor=1 Nurse=2 Midwife=3 Psychologist=4 Other=5 Missing value=99
A.6) How long have you worked in hospitals in total?	0-1 years=1 1-5 years=2 5-10 years=3 More than 10 years=4 Not applicable=77 Missing value=99
A.7) Have you encountered cases of domestic violence among patients in the hospital in the last 12 months?	Yes=1 No=2 Not applicable=77 Missing value=99

B) Questions about the training

B.1) Structure/Timeframe

a) In-person training	'Value given by participant' Missing value=99
b) Self-study	'Value given by participant' Missing value=99

B.2) Didactics: Which methods were used in the training you attended?

***Note to coders**: Please put 1 for every method participants have chosen and 2 if participants left the field blank.*

a) Input/lecture	If chosen: 1 If not chosen: 2
b) Group work/group discussion	If chosen: 1 If not chosen: 2
c) Videos	If chosen: 1 If not chosen: 2
d) (Self-)Assessment	If chosen: 1 If not chosen: 2
e) Case Studies	If chosen: 1 If not chosen: 2
f) Simulations	If chosen: 1 If not chosen: 2
g) Role Play	If chosen: 1 If not chosen: 2
h) Other	If chosen: 1 If not chosen: 2

B.3) On a scale from 1 (very bad) to 10 (very good): Please now rate some aspects of the training you attended.

a) Overall quality of the training	'Number given by participant' Missing value=99
b) Structure of the training	'Number given by participant' Missing value=99
c) Presentation of the content and teaching methods	'Number given by participant' Missing value=99
d) Expertise of the trainers	'Number given by participant' Missing value=99
e) Methodological and didactic competence of the trainers	'Number given by participant' Missing value=99
f) Relevance for working with victims of domestic violence in hospitals	'Number given by participant' Missing value=99

B.4) On a scale from 1 (strongly disagree) to 10 (strongly agree): How much do you agree with the following statements?

a) I can apply the content of the training in my area of work.	'Number given by participant' Missing value=99
b) After the training, I know more about domestic violence	'Number given by participant' Missing value=99
c) As a result of the training, I feel more confident talking to patients about domestic violence.	'Number given by participant' Missing value=99

d) The training makes it easier for me to raise the topic of domestic violence with colleagues in the hospital.	'Number given by participant' Missing value=99

C) Domestic Violence

C.1) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	'Number given by participant' Missing value=99
C.2) On a scale from 1 (none) to 10 (very high): How would you rate the impact of the training you just took part in on your knowledge?	'Number given by participant' Missing value=99

C.3) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

a) I know the most common forms of domestic violence.	'Number given by participant' Missing value=99
b) I know about the main risk factors for domestic violence.	'Number given by participant' Missing value=99
c) I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	'Number given by participant' Missing value=99
d) I have the tools to identify domestic violence and assess risks.	'Number given by participant' Missing value=99
e) I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	'Number given by participant' Missing value=99
f) I know about services, advice and support centres for victims of domestic violence in my area.	'Number given by participant' Missing value=99
g) I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	'Number given by participant' Missing value=99

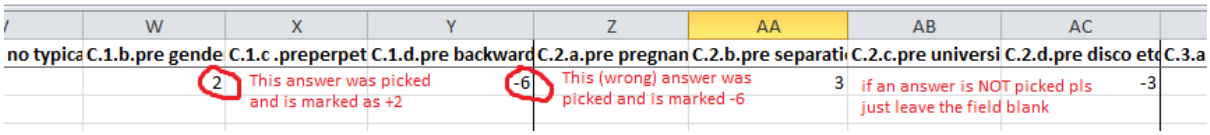
C.4) On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

a) It is easy for me to talk to patients about domestic violence.	'Number given by participant' Missing value=99
b) I recognise indicators for domestic violence.	'Number given by participant' Missing value=99
c) I can carry out a risk assessment and derive measures from it.	'Number given by participant' Missing value=99
d) I routinely include screening questions about domestic violence in my conversations with patients.	'Number given by participant' Missing value=99

e) I know when and how to refer (potential) victims of domestic violence to further/specialized counselling and support services.	'Number given by participant' Missing value=99
f) I have practice in creating documentation of injuries caused by domestic violence that can be used in court.	'Number given by participant' Missing value=99

D) Which of the following statements are correct?

Note to coders: *This part of the survey is a multiple-choice-assessment. Participants get a score (positive or negative) for each answer they have chosen. Please only report the answers, which have been picked.* ***If an answer has not been chosen by the participant please leave the respective field BLANK****:*



D.1) Which persons/groups are victims or perpetrators of domestic violence?

a) There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	+2
b) Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	+2
c) Perpetrators of violence are often charming and friendly in demeanour.	+2
d) Domestic violence is a problem of backward cultures.	-6

D.2) In which of the following situations is there an increased risk of domestic violence?

a) During pregnancy	+3
b) During and after a separation or divorce	+3
c) During university	-3
d) At a disco, clubbing or similar events	-3

D.3) Under what circumstances should healthcare professionals ask patients about domestic violence?

a) All patients should be routinely asked about domestic violence.	+5
b) Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	-3

c) Patients with conspicuous injuries or behaviour should be asked about domestic violence, regardless of the reason for their visit.	+1
d) Private issues should only be addressed if patients themselves indicate relationship problems.	-3

D.4) What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?

a) It is not ideal, but acceptable, if relatives or children of the patient translate.	-3
b) It is important not to enter into the conversation with preconceptions about victims and perpetrators.	+3
c) If an accompanying person is present, he/she should be included in the conversation.	-3
d) If patients are not willing to talk about the situation, this should be accepted.	+3

Codebook Pre-Course Survey for Students

A) General questions

A.1) Personal Code:	'Unique Code given by participant'
A.2) Gender	Female=1 Male=2 Diverse/non-binary/queer=3 Other=4 Missing value=99
A.3) Age (in years):	'Number given by participant' Missing value=99
A.4) Have you already been working in a hospital (e.g. internship)?	Yes=1 No=2 Missing value=99
A.5) Have you encountered cases of domestic violence among patients in the hospital in the last 12 months?	Yes=1 No=2 Not applicable=77 Missing value=99

B) Domestic Violence

B.1) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	'Number given by participant' Missing value=99

B.2) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

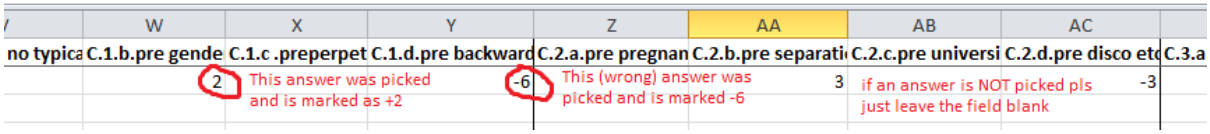
a) I know the most common forms of domestic violence.	'Number given by participant' Missing value=99
b) I know about the main risk factors for domestic violence.	'Number given by participant' Missing value=99
c) I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	'Number given by participant' Missing value=99
d) I have the tools to identify domestic violence and assess risks.	'Number given by participant' Missing value=99
e) I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	'Number given by participant' Missing value=99
f) I know about services, advice and support centres for victims of domestic violence in my area.	'Number given by participant' Missing value=99
g) I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	'Number given by participant' Missing value=99

B.3) On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

a) Dealing with domestic violence has been a relevant topic in my studies to date.	'Number given by participant' Missing value=99
b) I know indicators for domestic violence.	'Number given by participant' Missing value=99
c) I feel competent to communicate with victims of domestic violence.	'Number given by participant' Missing value=99
d) I know examples of screening questions about domestic violence…	'Number given by participant' Missing value=99
e) I know referral procedures to specialised counselling and support services…	'Number given by participant' Missing value=99
f) I can perform documentations of injuries caused by domestic violence that can be used in court.	'Number given by participant' Missing value=99

C) Which of the following statements are correct?

Note to coders: *This part of the survey is a multiple-choice-assessment. Participants get a score (positive or negative) for each answer they have chosen. Please only report the answers, which have been picked.* ***If an answer has not been chosen by the participant please leave the respective field BLANK****:*



C.1) Which persons/groups are victims or perpetrators of domestic violence?

a) There is no "typical victim" – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	+2
b) Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	+2
c) Perpetrators of violence are often charming and friendly in demeanour.	+2
d) Domestic violence is a problem of backward cultures.	-6

C.2) In which of the following situations is there an increased risk of domestic violence?

a) During pregnancy	+3
b) During and after a separation or divorce	+3
c) During university	-3
d) At a disco, clubbing or similar events	-3

C.3) Under what circumstances should healthcare professionals ask patients about domestic violence?

a) All patients should be routinely asked about domestic violence.	+5
b) Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	-3
c) Patients with conspicuous injuries or behaviour should be asked about domestic violence, regardless of the reason for their visit.	+1
d) Private issues should only be addressed if patients themselves indicate relationship problems.	-3

C.4) What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?

a) It is not ideal, but acceptable, if relatives or children of the patient translate.	-3
b) It is important not to enter into the conversation with preconceptions about victims and perpetrators.	+3
c) If an accompanying person is present, he/she should be included in the conversation.	-3
d) If patients are not willing to talk about the situation, this should be accepted.	+3

Codebook Post-Course Survey for Students

A) General questions

A.1) Personal Code:	'Unique Code as given by participant'
A.2) Have you filled in the pre-course survey	Yes=1 No=2

Note to coders: *If "yes" please leave the rest of the fields in the A) section* ***BLANK****. If "no" please fill them in (including the 99 for missing values).*

A.3) Gender	Female=1 Male=2 Diverse/non-binary/queer=3 Other=4 Missing value=99
A.4) Age (in years):	'Number given by participants' Missing value=99
A.5) Have you already worked in a hospital (e.g. internship)?	Yes=1 No=2 Missing value=99
A.6) Have you encountered cases of domestic violence among patients in the hospital in the last 12 months?	Yes=1 No=2 Not applicable=77 Missing value=99

B) Questions about the course

B.1) Structure/Timeframe

a) In-person training	'Value given by participant' Missing value=99
b) Self-study	'Value given by participant' Missing value=99

B.2) Didactics: Which methods were used in the course you attended?

Note to coders*: Please put 1 for every method participants have chosen and 2 if participants left the field blank.*

a) Input/lecture	If chosen: 1 If not chosen: 2
b) Group work/group discussion	If chosen: 1 If not chosen: 2
c) Videos	If chosen: 1 If not chosen: 2
d) (Self-)Assessment	If chosen: 1

	If not chosen: 2
e) Case Studies	If chosen: 1 If not chosen: 2
f) Simulations	If chosen: 1 If not chosen: 2
g) Role Play	If chosen: 1 If not chosen: 2
h) Other	If chosen: 1 If not chosen: 2

B.3) On a scale from 1 (very bad) to 10 (very good): Please now rate some aspects of the course you attended.

a) Overall quality of the course	'Number given by participant' Missing value=99
b) Structure of the course	'Number given by participant' Missing value=99
c) Presentation of the content and teaching methods	'Number given by participant' Missing value=99
d) Expertise of the trainers/teachers	'Number given by participant' Missing value=99
e) Methodological and didactic competence of the trainers/teachers	'Number given by participant' Missing value=99
f) Relevance in the framework of university course work	'Number given by participant' Missing value=99

B.4) On a scale from 1 (strongly disagree) to 10 (strongly agree): How much do you agree with the following statements?

a) The contents of the course relate to other areas of my university studies.	'Number given by participant' Missing value=99
b) After the course, I know more about domestic violence	'Number given by participant' Missing value=99
c) As a result of the course, I feel more confident talking to patients about domestic violence.	'Number given by participant' Missing value=99
d) The course makes it easier for me to raise the topic of domestic violence with colleagues at university or in the hospital.	'Number given by participant' Missing value=99
e) The course provided important content and training, which was lacking from other university course work.	'Number given by participant' Missing value=99

C) Domestic Violence

C.1) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of domestic violence?	'Number given by participant' Missing value=99

C.2) On a scale from 1 (none) to 10 (very high): How would you rate the impact of the course you just took part in on your knowledge?	'Number given by participant' Missing value=99

C.3) On a scale from 1 (none) to 10 (very high): How would you rate your knowledge of the following topics?

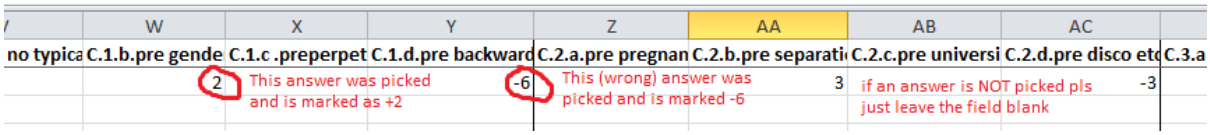
a) I know the most common forms of domestic violence.	'Number given by participant' Missing value=99
b) I know about the main risk factors for domestic violence.	'Number given by participant' Missing value=99
c) I know and observe relevant guidelines, laws and regulations when working with victims of domestic violence.	'Number given by participant' Missing value=99
d) I have the tools to identify domestic violence and assess risks.	'Number given by participant' Missing value=99
e) I am aware of barriers in the healthcare system, which make it difficult for people to talk about domestic violence.	'Number given by participant' Missing value=99
f) I know about services, advice and support centres for victims of domestic violence in my area.	'Number given by participant' Missing value=99
g) I am familiar with the violence protection system and the individual steps from an incident of violence to court proceedings.	'Number given by participant' Missing value=99

C.4) On a scale from 1 (not at all) to 10 (completely): To what extent do the following statements apply to you?

a) I know indicators for domestic violence.	'Number given by participant' Missing value=99
b) I feel competent to communicate…	'Number given by participant' Missing value=99
c) I know examples of screening questions…	'Number given by participant' Missing value=99
d) I know referral procedures...	'Number given by participant' Missing value=99
e) I can perform documentations…	'Number given by participant' Missing value=99

D) Which of the following statements are correct?

Note to coders: *This part of the survey is a multiple-choice-assessment. Participants get a score (positive or negative) for each answer they have chosen. Please only report the answers, which have been picked.* ***If an answer has not been chosen by the participant please leave the respective field BLANK****:*



D.1) Which persons/groups are victims or perpetrators of domestic violence?

a) There is no “typical victim” – people of any age, social class, origin, gender, sexual orientation, etc. can be affected.	+2
b) Domestic violence is often the result of gender-specific inequalities and therefore mainly affects women and girls.	+2
c) Perpetrators of violence are often charming and friendly in demeanour.	+2
d) Domestic violence is a problem of backward cultures.	-6

D.2) In which of the following situations is there an increased risk of domestic violence?

a) During pregnancy	+3
b) During and after a separation or divorce	+3
c) During university	-3
d) At a disco, clubbing or similar events	-3

D.3) Under what circumstances should healthcare professionals ask patients about domestic violence?

a) All patients should be routinely asked about domestic violence.	+5
b) Direct questions about domestic violence can have a traumatising effect and should therefore be avoided.	-3
c) Patients with conspicuous injuries or behaviour should be asked about domestic violence, regardless of the reason for their visit.	+1
d) Private issues should only be addressed if patients themselves indicate relationship problems.	-3

D.4) What should be considered when addressing domestic violence? How should healthcare professionals manage the situation?

a) It is not ideal, but acceptable, if relatives or children of the patient translate.	-3

b) It is important not to enter into the conversation with preconceptions about victims and perpetrators.	+3
c) If an accompanying person is present, he/she should be included in the conversation.	-3
d) If patients are not willing to talk about the situation, this should be accepted.	+3

7.8. Annex 8: Guidelines & template for training observations for partners

Training Observation Template

Introduction

The observation of trainings by members of the VIPROM-Team is part of our **mixed-method evaluation strategy**, which aims to include as many different perspectives as possible on the trainings. Training observation will be conducted at all six training sites with two observers per sight to gather "thick" data, which will add to the insights gained through questionnaires and trainer feedback.

The observation focusses on two areas:

a) **Methodology and didactic approach of the trainings**
b) **Participation**

Additionally we ask the observers to pose a few questions to trainers directly after the training to include

c) **Trainers' insights**

First of all, these guidelines are meant to make the observation easier and help you report results in structured way. They are not meant to be a fixed set of rules or limit what you can or cannot report! As trainings are necessarily tailored to each location and the specific group of participants we can only provide you with a framework.

Please feel free to include everything you find noteworthy about the training even if it is not mentioned in the guidelines.

Should you have any questions, please don't hesitate to get in touch with IKF!

Observation as a method ("How to observe")

Both observers should already know the VIPROM-contents beforehand so they can focus on the training situation and dynamics within the group rather than focussing mostly on the content. Even though it is important to give an outline of the contents and the schedule of the training this should be a relatively small part and does not have to be extremely detailled.

Ideally the **work is divided** between the two observers, with one person focussing mainly on the interaction between the trainer and the group and the other focussing mainly on the behaviour of participants and dynamics within the group. If parts of the training are group work it is best to split up and observe two different groups.

Notetaking – including context (e.g. room, seating…), small details of behaviour and verbatim quotes of especially important interactions – is vital. In most cases it is best if each observer takes notes by hand and in their native language during the training and the two of them afterwards complete the reporting template together (in English) as soon as possible (while memories are still fresh). The goal is to arrive at a **"thick description"**, i.e. giving readers, who have not been there themselves, a vivid image of what the training was like. In order to

achieve this, the focus should be on the description, not on interpretation (e.g. don't just write that a discussion "went well", but describe the exchange).

Sensitizing questions („What to look for")

With regards to

a) **Methodology and didactic approach of the trainings** important things to look for include the following:

- How do trainers introduce themselves (purely professional or personal too?)
- How do trainers make sure the training fits participants' needs? Which tools do they use to ensure that?
- How do trainers create a safe space?
- How do trainers activate participants' prior knowledge? How do they engage them? And how to participants react?
- Which kind of relationship do trainers establish towards the participants? How do they deal with hierarchies? What role(s) do they perform in the course of the training (e.g. teacher, moderator, counsellor…)?
- How does time management work? Is there enough time allocated to each topic? How do trainers manage to move from one topic to the next?
- Which didactic methods do trainers use? How do participants respond to them?
- What methods or issues spark discussion?
- How do trainers close the training?
- Were there any challenging situations? How did trainers manage those?

b) Participation

- What is the atmosphere like?
- Which expectations (if any) do participants voice?
- What kind of relationships emerge among participants (e.g. are professional hierarchies visible, does gender or age play a role)? How do trainers deal with this?
- Is everyone actively participating? How? Are there "spokespersons"?
- How do trainers ensure – equal? – participation?
- Do participants accept the training as a safer space? Do they seem to feel free to ask and discuss "everything"?
- Do participants discuss their own professional or even private experiences (e.g. with relation to case studies)?
- Which topics are of particular interest to participants? Are these interests rather individual or are they shared by the whole group?
- Were there any challenging situations? How did participants navigate those?

Description of context

In order to truly understand your account we ask you to provide us with information on the context, i.e. the training itself.

- Training:
  - Timeframe/duration of the training
  - Location: Where did the training take place and what was the location like?
  - Main topics and approximation of time allocated to each
  - If relevant: role of online/self-study
- Trainers: Professional background and experience
- Participants:
  - How many participants were there and who were they? (e.g. mixed group, nurses, doctors, students)?
  - If possible describe the group by gender, age range and professional backgrounds.
  - If possible add information about whether they had prior knowledge of DV
  - (We don't need names or detailed individual descriptions unless these prove important in the course of the training).

Talking to trainers

Please have a short chat with the trainers directly after the training to gather their insights. This does not have to be long, nor is it a formal interview. We suggest the following questions:

- Over-all impression of the training? Are they satisfied? Did they achieve their training goals?
- What went especially well?
- Were there challenging situation (from the perspective of the trainers)?
- Is there anything they would do differently next time? Any recommendations they would like to give to other trainers?

Reporting template

Context

Training

Timeframe/duration	
Location	
Main topics (and time)	
Face-to-face/self-study	
Further comments	

Trainers

Trainers background and expertise	
Further comments	

Participants

Number	
Professional backgrounds	
Gender: men / women / queer / other	
Age range	

Prior knowledge on DV	
Further comments	

Methodology and didactic approach of the trainings

Description of methods and approaches used by trainers and of the relationship they established towards participants following the sensitizing questions above.

Please include concrete examples to help us truly understand the situation!

(1.500-5.000 characters)

Participation

Description of participants' behaviour, group dynamics, debates and exchanges – please follow the sensitizing questions above.

Please include concrete examples to help us truly understand the situation!

(1.500-5.000 characters)

Trainers' insights

Description of trainers' immediate impressions as told to you in your after-training chat. (800-2.000 characters)

Further comments

Any further information you would like to give or comments you would like to make!

Thank you!

7.9. Annex 9: Trainer feedback-form

Trainer Feedback on national TtT-Events

As part of the VIRPOM evaluation effort we ask all participants of national Train-the-Trainer-Events to give us feedback on their training experience.

The focus of the feedback is on your impression of the impact of the trainings and on methodical approaches, but please feel free to provide comments and advice on any issues you deem important!

Thank you very much!

If you have any questions on this feedback form don't hesitate to contact us: [E-Mail]

1.) Please tell us a few things about yourself

Gender: O female
O male
O non-binary/queer/diverse
O other: _____

Age: _____ years

Experience with DV in the medical sector since _____ years

Experience training medical professionals on DV since _____ years

Professional background/expertise (please check all that apply):

O doctor
O nurse
O gynaecology
O ER
O paediatrics
O dentist
O psychologist
O social worker/counsellor
O other: _____

Further Comments (optional):

2.) **What was your impression of the VIPROM Train-the-Trainer-Event? Please rate the following aspects from 1 (lacking/very bad) to 10 (very high/very good).**

	1-10
Overall quality of the training content	
Structure of the training	
Presentation and didactic methods	
Relevance of training contents for DV-related work in hospitals	
Relevance of training for your own DV-related trainings	

Further Comments (optional):

3.) **Do you agree with the following statements? Please rate from 1 (strongly disagree) to 10 (strongly agree). If a statement does not apply to your situation, please leave a blank).**

	1-10
The training content was interesting for me.	
I can use the contents in my daily work at the hospital.	
I feel well prepared for my own VIPROM-trainings.	
I learned something new during the training.	
The training platforms (modules) are helpful for the preparation of my own trainings.	
If VIRPOM trainings are delivered broadly it will make a difference for the way hospitals support victims of DV.	

Further Comments (optional):

4.) **Last, we ask you for some more detailed feedback on what you especially liked or disliked about the trainings.**

Which aspects of the training did you find especially good and/or helpful?

Was there anything you did not like? What could have been better?

Further Comments (optional):

7.10. Annex 10: Trainer consent & contact list for focus groups

Trainer Contact List

Trainers' feedback is one of the most valuable instruments for improvement of the VIPROM trainings and training materials. As part of the evaluation (international) group discussions will be held with trainers about their experiences with the VIPROM trainings, after trainings in the different countries have been held.

The discussions will take place online in March 2025 (hosted by IKF) and will last approximately two hours.

In order to be able to contact you in spring 2025 with an invitation for one of the group discussions, we ask you to please give your contact details and signature below! (Of course this does in no way oblige you to take part in the group discussion! It only allows us to contact you.)

Thank you very much!

If you have any questions don't hesitate to contact us: [E-Mail]

Name	E-Mail	Country of Trainings	Signature